MENTAL HYGIENE

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THE STORY OF PSYCHOTHERAPY

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FROM the standpoint of medical science, the human organism must be considered a unity, a psychobiological whole. Separation of the individual into two distinct parts, one physical and one mental, is to a considerable extent artificial. Psychiatry, in its attention to disorders of the mind, has from the beginning been reluctant to consider the mental life apart from its organic foundation. This strict adherence to principle is commendable in theory, although it has often been maintained at the expense of progress, through anchoring a dynamic psychology to a more static biology. In the field of general medicine, interest is now extending beyond vague considerations of the interdependence of mind and body. Attempts are being made to gain more detailed knowledge of the relationship of those psychic and physical factors which find common ground in maladies such as certain digestive, endocrine, and cardiac disorders. The new understanding of mental pathology, which has followed tardily in the wake of earlier established knowledge of physical pathology, offers fresh possibilities for the empirical approach to complex problems of human illness from the double standpoint of psyche and soma.

However, from the practical standpoint of treatment, it is still useful to consider the individual not one person, but two—a physical man and a mental man. When anything is wrong and something needs to be done to make it right, the

treatment required varies according to which man it is. If an individual falls off a roof and breaks his leg, the results are primarily physical, and he requires physical treatment. If this same person, instead of suffering from a fall, becomes ill after experiencing some grievous disappointment, the resulting condition is in the main a mental rather than a physical one, and help for him must be of a mental nature. A large number of the ills to which mankind is heir are much more akin to the results of disappointment, frustration, and the like, which affect the mind, than they are to accidents and diseases, which affect the body. Treatment by mental means of these disorders and difficulties of the mental man is called psychotherapy.

To trace the beginnings of the art of mental healing, it is necessary to go far back in history. From the time that primitive man developed to the point where he could live in groups, some attempt was made to cure disease. Prominent among early methods were charms and incantations which, if responsible for any effects at all, acted as a rude sort of psychotherapy. To early man, lacking acquaintance with the natural laws of the physical world, storm, famine, and pestilence appeared as the wilful acts of capricious gods, while ordinary sickness was interpreted as possession by evil spirits. Small wonder, then, that there was little intelligent treatment for ills of body or of mind. Developing knowledge of natural phenomena dispelled belief that the world was directed by the whims and passions of animate beings and brought the downfall of the gods, but long after a dawning rationality began to rule in the comprehension of the inanimate world, conceptions of human illness, physical and mental, remained enshrouded in ignorance and superstition.

The history of general medicine can be painted with a few broad strokes. At the height of the ancient Mediterranean civilizations, there were manifestations of an intelligent and humane medical science and art. Due to causes not wholly clear, this early light was soon dimmed, and dense and impenetrable darkness followed from near the beginning of the Christian era up to three hundred years ago. Then new points of light appeared, which flickered but faintly until less than a century ago, when there burst forth that brilliant and

steady-growing illumination which marks the modern period. Put in other words, most of the progress in medical science away from superstition and abysmal ignorance has occurred within the span of a few generations. To be sure, medicine in this respect did not stand alone; but in the sleep of the centuries, which it shared with all departments of knowledge, medicine, the healing art, slumbered more heavily than the others.

The saddest chapter of all concerns the reception given by the world to those pioneer discoveries which made possible the modern scientific age in medicine. Without exception, they were met either by crushing indifference or by scorn and denial. Church, medical profession, and public vied with one another in heaping calumny and opprobrium upon those who would lead them toward a new enlightenment. To-day there is less opposition to change than formerly, but the resistance of entrenched conservatism still manifests itself to the detriment of progress in medicine, with the center of conflict shifting from the realm of body to that of mind.

The Renaissance, which terminated the Dark Ages, did not apply to psychotherapy and for a long time thereafter this field was renounced by medicine and left to the joint possession of charlatanism and religion. Here was strange company, to be sure, but the two had one thing in common in that both operated outside the field of natural phenomena and the scientific approach. With the exception of healing through religious faith, psychotherapy came to have a bad name, on account of its association with ignorance, superstition, and fraud. From the standpoint of science and intelligent public opinion, this method of treatment fell into disrepute, from which it has emerged only in recent times. In other words, psychotherapy, like some people, has an unsavory past which it has not been easy to live down. The presence of psychotherapy in some form has, however, always been inevitable, on account of the nature and needs of psychic difficulties. So far as medical men were concerned, they avoided a dilemma by practicing psychotherapy without knowing what they were doing, or else hiding it behind some physical agency, such as drugs or diet, which seemed to them more respectable. Meanwhile, impostor and quack flourished, partly due to the

refusal of official medicine to recognize this field. In medieval times, much of surgery was turned over to barbers as beneath the dignity of the medical profession. Later, psychotherapy, for equally depreciatory reasons, was left for the most part to the charlatan.

In a pioneer civilization, the first concern of the inhabitants is to subdue the wilderness and look after the physical necessities of food, clothing, and shelter. The refinements of life and higher cultural developments must wait until later. Medicine, until somewhat recently in its history, has always operated in pioneer fashion, struggling with the dangers and diseases that resisted the progress of civilization as stubbornly as any army of hostile barbarians.

This struggle with the physical enemies of accident and disease has been the most important and the chief concern of medicine. It was for work in this field that medical education was first developed, and toward which it is still mainly directed. To-day, in the more civilized countries, the dramatic frontier of medicine is disappearing. With few exceptions, the scourges of epidemics, infections, and acute emergencies are fairly well under control. Medicine in logical progress is able to give increasing attention to the more insidious and chronic disorders which interfere with efficiency and happiness. Many of these disorders are physical; for example, the degenerative diseases of various organs of the body. But there are included also those minor mental disorders called by the medical profession psychoneuroses, or neuroses, and grouped by the layman under the general term, nervousness. These latter conditions occupy the field in which psychotherapy is most effective.

The neuroses have had to wait in the evolution of medicine until more important and pressing business was disposed of. There is nothing acute or very exciting about them. They do not sweep through communities and bring sudden disaster and death. The disability and suffering are spread thin over long periods, and are confined to the individuals concerned and a few people in close contact. Nervous troubles have been a matter which, so far as both medicine and society in general were concerned, could be left for leisurely consideration. It is also probable that nervous troubles increase with the advance

of civilization. In a primitive community mental energies are largely absorbed in struggles with the environment; the weak are pushed aside and the strong survive. As life becomes more secure in a physical sense, and at the same time more involved in its social and mechanical complexities, finer degrees of mental adjustment are demanded, with increasing chance for failure in the process, and resulting nervousness.

Of course, the more serious mental disorders, the so-called insanities and other gross abnormalities and defects in mind, have always been of concern to society, and people who could not fit into group life on account of these maladies had to be cared for by others. Until comparatively recent times they were looked upon more as criminals than as sick people, and were treated accordingly. Gradually, humane and enlightened opinion brought the mentally ill into the domain of medicine. Some of the most serious disorders proved to have definite physical causes, such as syphilis, alcohol, and so forth, and the work of medicine up to the present time has been directed toward physical treatment where it was indicated, and otherwise toward general custodial care and so-called social therapy. Specific psychotherapy, as a means of curing serious mental disorders, is in its earliest infancy with an unpredictable future.

Leaving out of consideration mental disorders which require long-time institutional care or its equivalent, it is, then, a fact to be accepted that there are an enormous number of people, with bodies sound beyond the power of medical science to prove otherwise, who are handicapped by mental difficulties that show themselves in the familiar form of the neuroses. It is equally a fact that often mental treatment can help these people while physical treatment can not. Disorders of the mental man that demand psychotherapy may result from two groups of causes: first, those that are external, and second, those that are internal—*i.e.,* within the mind itself. About the first group, of course, there is nothing obscure. It is recognized by all that adversity and hard luck, "the slings and arrows of outrageous fortune," may produce distressed states of mind which cannot be permitted to continue and which somehow must receive help. Tragedy, disappointment, bereavement, and general reactive unhappiness are common

enough to be understood in some degree by all. The second group of causes, those which come from within the mind, are far less clear than those which come from outside, and are not a matter of common knowledge. These causes are hidden so that they cannot be seen, and even though the results are expressed in nervous symptoms, whatever is responsible for them seems to be something alien and inexplicable to the sufferer himself as well as to others. The universal plaint of such people is, "I don't know why I feel this way. There is no sense in it."

The well-adjusted personality needs little specific psychotherapy for mental states produced by causes that come from outside circumstances. Man has the power within himself for spontaneous healing, and however crushed and unhappy he may be, seldom becomes nervously ill. The benign influence of time, the demands of the world of activity, and the aid and sympathy of family and friends gradually bring him back to normal. It is those people who have a predisposition to neuroses who need the help of mental medicine. It is the conditions arising from inner causes that require technical psychotherapy, whether or not these causes operate alone or are reinforced by outside factors. Modern medical psychology is gradually revealing the nature of these inner difficulties, thereby enabling science to penetrate realms formerly reached, if at all, only by a kind of sympathetic intuition.

It must be admitted at once that the medical profession has no monopoly of mental means for aiding mental distress. Everyday psychotherapy, in the form of counsel, advice, and encouragement, is constantly being employed by family, friends, and other groups of people. The question at issue here is to what extent can special training, based on scientific knowledge of the mind, extend this art of psychotherapy beyond the simple everyday methods sufficient for everyday ailments, but inadequate for more deep-seated difficulties.

The beginning of anything approaching a scientific psychotherapy is associated with the name of Mesmer, who was an eighteenth-century Viennese physician of sound culture and broad humanitarianism. About the time of the American Revolution, he moved to Paris and became much the vogue among the French aristocracy. Mesmer first grasped the prin-

ciple of so-called suggestive psychotherapy in the hypnotic state. Unfortunately, he encumbered his art with fantastic theories of animal magnetism and some strange fluid which passed from operator to patient, and gave his treatments in a setting of Oriental mystery, with the aid of magnets, wires, and other bizarre paraphernalia. Sharing the fate of many other pioneers, Mesmer was formally repudiated by the medical profession in Vienna and Paris, and an investigation by an official tribunal, to which America contributed Benjamin Franklin, solemnly declared that his system was another fact in the history of human error and a great proof of the power of imagination. Nevertheless, Mesmer succeeded in immortalizing himself, and some of his work, shorn of false theories and side-show trappings, must be accepted as the basis of modern psychopathology and the first substantial contribution to a sane psychotherapy.

The principles of Mesmer remained under a cloud until the middle of the nineteenth century. At that time, James Braid, an English surgeon of high standing, turned his attention to the subject, and with the clear vision of the scientist, soon saw that he was not dealing with strange body fluids or animal magnetism, but with purely mental phenomena. Braid is said to have been the first to use hypnotism to describe the mental events involved in the use of Mesmer's scheme of treatment. The reputation of Braid as a surgeon, and his scientific methods of investigation, did much to gain recognition in the medical profession and remove psychotherapy from the realm of the black arts.

One generation more and Paris again became the center of progress in these fields, under the leadership of Charcot, whose work in neurology had won international fame. The high position held by him in general science and in medicine, plus the unusual vigor of his personality, made his influence far-reaching. He forced a reluctant medical world to accept the fact that a wide variety of illnesses can be produced by purely mental causes and should be treated by mental means. In 1882, the French Academy of Medicine, after much hesitation, permitted Charcot to present before it his conclusions in regard to hysteria and hypnotism. This marked the official admission of psychotherapy into respectable company,

and was the birthday of the scientific treatment of illness by mental means. The inertia and prejudice toward what is new and different were reinforced in this case by the dark shadows of a questionable past, so that both medical profession and the general public have been slow to give psychotherapy its place in the sun, and some to this day are unaware that it was ever born.

Pierre Janet, a pupil of Charcot, has been the outstanding figure in the transitional period between the psychotherapy of the nineteenth century and that of the present day. The brilliant and pioneer work of Janet emphasized the need for painstaking investigation of individual patients, in contrast to the more simple, but less accurate application of general principles, and will long stand as a model of close observation and sound clinical methods. He was the first to recognize that nervous illness is not something that seizes upon the individual suddenly, but is instead the end product of the whole life history and psychological evolution.

The World War gave a healthy impetus to the subject of mental treatment on account of the compelling number of nervous disorders that occurred among the soldiers of all nations, and progress since then has been rapid. The method of hypnotism and its derivatives, after two decades of great popularity, have rapidly declined in favor of the so-called analytic approach which is becoming more and more prevalent in the present era. In the psychotherapy of the present, Sigmund Freud, of Vienna, is the leading figure, and the Freudian period may be said to have had its beginning in 1909, when Freud and some of his colleagues were invited to attend a psychological congress at Clark University, in Worcester, Massachusetts. Thus prophets with little honor at that time in their own countries were given their first official recognition in a foreign land.

The history of psychotherapy from earliest times to the present can be summarized and recapitulated in a few words: Magic, Occultism, Gross Superstition, Religious Mysticism, Charlatanism; Mesmer, Braid, Charcot, Janet, and Freud.[1]

[1] It goes without saying that a complete list would include many other illustrious names of those from all nations who have made their own special and important contributions.

Progress from primitive magic to a scientific psychotherapy has come about through discarding the miraculous and withdrawing the emphasis on external agencies as important factors in cure. Parallel with this has developed increasing insistence upon the discovery and application of those laws of the mind which are proving more and more clearly to be as definite as the laws of the body.

Among all the great movements in this field, the present analytic one bids fair to be the most striking and far-reaching. Progress in medicine, as in other affairs of men, does not go on steadily, but great changes come suddenly, as a result of the work of some individual or through some special set of circumstances. Pasteur, the French chemist, searching in his laboratory to find out what caused undesirable fermentation in wines, made discoveries about bacterial action that were vital to medicine and surgery and that have led to more progress in these fields since his time than in all previous ages put together. Freud, a generation after Pasteur, from economic necessity rather than by choice, became a practitioner in medicine and gave up his chosen field of physiological research. By studies that were in the beginning a by-product of his attempts to cure nervous patients, medical psychology has been revolutionized. It may not be too visionary to look forward to an era in medical science in which developments in relation to the mind will compare with those that have taken place in the last century in knowledge and treatment of the body.

Freud's great contribution to the century of progress in science has been the discovery and partial exploration of the unconscious mind. Before his work, little was known of this region of the unconscious.[1] Such glimpses as were made possible by the intuitive genius of poet and philosopher were all too vague for the practical usage of science. Before Freud, the conscious part of mind was considered to be the whole. Consciousness and mind were declared synonymous. The mental activity of a person asleep or in stupor was supposed to be in complete abeyance. Knowledge about the mental life

[1] A hundred years earlier, Herbart, and later Benecke and Lotz, postulated unconscious psychic processes, but until the practical applications made by Freud, these concepts had only academic significance.

was limited by what one could learn about one's self and describe to others by observation and introspection. To nineteenth-century science, purged of mysticism and the supernatural and glorying in its new freedom, methods of procedure seemed simple. To learn about any subject, it was only necessary to examine it without preconceived bias, and to observe, measure, experiment, and establish laws. It has become clear that this procedure, when applied to mind, falls far short. By ordinary observation or introspection only the surface veneer is reached. Consciousness is nothing but the façade of a vast hidden structure. Most of the human mind operates outside of consciousness, and beyond the region of that direct examination which can be applied to the external world. The main mental forces which motivate conscious thought and determine behavior lie in the unconscious. When the forces of the unconscious are organized into a smoothly running, unified whole, then the conscious self is in a fortunate position and has a maximum opportunity for choice and independence. If, on the other hand, there is conflict and discord in the depths of the mind, the individual is far less a free agent. The relation of the conscious mind to the forces of the unconscious has been pictured as a rider astride a spirited horse; some of the time he has full power to guide and control, at others he may be obliged to conform in some degree to the will of his mount, while not infrequently it runs away with him altogether.

These revolutionary concepts of the structure of man's mind acted at first as a sad blow to self-esteem. They overthrew a cherished and universal conviction that, if time and effort were given to the task, each individual could understand his own mind and in large degree control it. When some three hundred years ago Copernicus demonstrated beyond possibility of doubt that this planet was not a central object in space, there was a mighty protest, and he was in danger of execution for heresy. To be thus summarily removed from the center of God's universe to its periphery was a shattering disillusionment to mankind which no one would willingly accept. However, the new control over the physical world made possible through the application of this knowledge far outweighed the seeming loss, and in time man's self-con-

fidence was restored and the early wounds to pride were healed. Something similar has occurred as a result of the new knowledge of the mind. The increase in capacity for self-understanding makes possible a greater measure of self-direction and control, and thereby compensates for that chastening of the spirit which followed the first realization of so much helplessness.

It would not be the truth to say or to imply that the work of Freud is fully accepted by the scientific world, but it is a fact beyond dispute that some of the fundamental principles with which his name is connected are a dominant influence in the fields of psychotherapy and psychiatry at the present time. If proof is demanded, it is only necessary to turn to current literature and note the abundance of Freudian formulations, references, and terminology. While before Freud surprisingly little was known about the nature of nervous troubles beyond their superficial manifestations, it did not follow that treatment was ineffective. Certain definite methods, variously termed suggestion, persuasion, reëducation, "directorship" and so on, had been developed. In addition, certain individual physicians, by some sort of intuitive art, without following any clear-cut method, had remarkable success in healing the nervous ills of their patients. The great pity is that their special procedure could as a rule be only vaguely formulated, even to themselves, and as a result they were wholly unable to pass on their skill to others. Since the work of Freud, the whole status of psychotherapy has changed, and much of the mystery surrounding it has disappeared. With insight into the workings of the unconscious mind, it can now be better understood what forces are operative, and what changes take place when various methods of treatment are employed. There has also been revealed something of the secrets of the intuitive art of the physician who is by nature especially gifted in this field. As a result, it is no longer necessary to trust chiefly to some inborn knack as a preparation for psychotherapy. More and more, competence in its practice can be taught and learned like any other medical procedure.

In addition to revealing contributions that deal with psychotherapy in general, Freud evolved a new method called

psychoanalysis, which is distinct from those preceding it in various striking respects. Its purpose is to reach and modify the unconscious mind to a depth and degree rarely to be accomplished otherwise. This is achieved by the development of a self-knowledge extending far beyond the usual meaning of the term. With this goal in mind, psychoanalytic treatment concentrates mainly on the subjective life of the patient and reduces to a minimum guidance and support in external affairs. In so far as immediate aid of this nature is needed, it can best be obtained elsewhere, in order not to confuse the issue and divert attention from the special business of analysis. The psychoanalytic method follows set rules, and the physician who is to become skillful in its practice must have special and intensive training over a period of years; psychoanalysts, like surgeons, are made, not born. The treatment is time-consuming in the extreme, and thus, at least in its present form, is impracticable for wide application. It makes unusual demands upon the patient for participation and self-help, and therefore, to be successful, requires a selection of subjects with fundamental vigor of personality and good basic potentials for mental health.

The present status of psychotherapy as a whole may be summarized as follows:

First, all the older pre-Freudian methods are still usefully operative, with a gradual simplification and change of emphasis in their theory and practice away from strange and obscure forces toward known laws of the mind.

Second, some of the contributions of Freud have been taken over by most psychotherapists, largely in the direction of so-called reëducation. This is an attempt to help the patient to profit by an increased knowledge of himself, so far as this can be accomplished by ordinary teaching methods.

Third, the formal psychoanalytic procedure is available in appropriate cases as an attempt to correct difficulties that are too deep-lying to be reached otherwise. It stands to-day as the most thoroughgoing means available to effect changes in those buried regions of the mental life where lie concealed the basic roots of the more important neuroses. It is for the most part employed as something of a last resort when other more simple methods have failed, or are obviously inadequate.

It is referred to, not inappropriately, as the major surgery of psychotherapy.

Fourth, in all psychotherapy there is increased recognition of the important part played by those obscure factors, the special "personalities" of physician and patient and the emotional relationship between them. In psychoanalysis, these factors, under the term "transference relation," are deliberately made use of as the main dynamics of the treatment. To a considerable degree this can be done in a controlled and measured fashion, instead of permitting such forces to operate without the awareness of either physician or patient or to be disregarded by them as incidental to the main business. It is the understanding use of these forces of transference that makes possible penetration and revelation of the patient's unconscious mind.

Fifth, it remains for the future to work out satisfactory eclectic procedures of psychotherapy that may apply with some specificity to various kinds and degrees of nervous trouble among people at various cultural and economic levels.

COLLEGE STANDARDS AND HUMAN VALUES

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IN its report for 1929, the Carnegie Foundation for the Advancement of Teaching published a most significant article by Dr. William S. Learned, on the relationship between secondary and higher education in Pennsylvania,[1] where an educational commission had been requested to study that particular phase of the larger problem of adapting mass education to the needs of individuals, which it is hard for a vast organization to take into account. As things go now, a pupil's "private aims, insights, and ambitions . . . go for naught if he disregards the premiums set by authority for the mass," and his teacher's first concern has to be "to work acceptably in the organization," which "often sorely impedes that child whom it would serve." Accordingly, "for years to come it must be our object to make this process of education not only universal, but effectively personal as befits the individual concerned; to insure, not that each child be tarred with the educational brush, but that he be given a substantial, appropriate, and penetrating experience—to minimize the mechanism, to magnify the teacher, and above all to keep sacred and alive in the pupil that subtle combination of freedom and obligation that makes intellectual growth a precious and satisfying thing."

To this end three bits of new machinery were suggested:

1. A system of very comprehensive objective tests carefully prepared by outside experts, to supplement or replace the usual course-credit machinery of high schools and colleges.

2. The use in colleges and high schools of cumulative-record cards containing what one really wants to know about an individual one is trying to help—records not only of attendance

[1] *Study of the Relations of Secondary and Higher Education in Pennsylvania.*

and marks, but of "instructive facts such as physical health, the continuity of certain dominant abilities through high school and college, pursuits and achievements in leisure, vocational experiences, economic situation, personality, mental well-being, home and family background." At present these and many other items of importance are left wholly out of account. "In the house of his Alma Mater a student enjoys for four years the personal anonymity of a transient guest in a hotel."

3. Official advisers for college students, especially freshmen, who will use the records, and give intelligent and conscientious advice to their charges, thus restoring some of the old intimacy of student and teacher, rarely found now outside of a graduate school. This is rather expensive and has proved hard to establish in any effective official way.

I may add that this business of official adviser is not always so good as it looks. Most college teachers know nothing about educational aims and values, about individual psychology, or about their own limitations. They often think in terms of subjects taught and departmental rivalries, and those amongst them who like to get themselves into managerial positions are liable to be those who are least capable of patiently feeling their way into the obscure, half-conscious attitudes of their charges and helping them to clarify and integrate their own inward drives. An "efficient" individual, turned adviser, is likely to impose decisions and to leave his clients as inwardly confused, dependent, and infantile as ever. The more docile they are, the more readily they will swallow his advice; and the more rapidly he can dispose of them, the more "efficient" he is. He may not remember that *im-position* and *e-ducation* are contradictory terms, and may fail utterly to realize that much apparent outward chaos may be the price of inward order. College courses can be correlated on the basis of superficial similarities and traditional groupings as "English," "Modern Languages," "Ancient Classics"; or on the basis of practical necessity as in medicine, where many different disciplines are brought to bear on the healing art; or on the basis of an individual's inward needs for purposes of his own, social or otherwise, that he can hardly formulate and might hesitate to confess if he could. An adviser who

cannot think much beyond the first will find it hard to sense the last.

To return to the cumulative-record cards. At the time of the 1929 report, they and the objective examinations were already in use in all the coöperating colleges for members of the class of 1932, and already they were suggestive: "In their records a type of pupil that is unquestionably 'college minded' stands out at once. When tested without previous warning or preparation, he shows clearly and repeatedly that *ideas* are his field. When presented to him, they stick and grow in his mind. To what extent this type is consistent in its growth, and in what numbers other pupils, now mediocre in this respect, may develop power—these are parts of our problem." With "truer pictures of youthful development . . . our checkered and piecemeal curricula, our rigid classifications, and our curious formula for estimating achievement should give place to a service in aid of expanding knowledge both more flexible and more coherent."

Once in the delicate days of yore I had a lady colleague who declared that mathematics was a wonderful study for girls "because it was so pure." Why they hated it, she never told. But perhaps there is more than prudery in her naïve remark. Plato wrote of a Heaven above the Heavens where we might hope to find Ideas in all the purity of absolute abstraction and behold them in our joy; and there are those to whom his words have meaning. This "college-mindedness" does exist, though the name may beg a question. So it is not surprising that in a later (1933) report on the Pennsylvania study,[1] Dr. Learned gets back again to his Ideas, though with a different metaphor and with the accent now, not on college-mindedness itself, but on college methods; for in the four-year interval the objective tests had been tried extensively and had shown indubitably that if thinking is the fundamental process in education, we "have no alternative to revolutionary changes in present methods." Thinking, you see, is conceived of here as the relating of ideas, and you can't relate them unless you have had them and have built a lot of them into a closely knit structure where they can be retained. So Dr. Learned says that the student whose teachers have helped him to sketch the

[1] *Knowledge as a Factor in Education—The Tests and Their Implications.*

outlines of such a building for his own erecting "thinks of neither term nor years, but only of the perfecting of his structure up to the final moment when it must undergo inspection. His motivation is intrinsic; it is by far the most compelling drive in all genuine learning—namely, a vividly conceived intellectual goal."

But, he continues, we Americans have learned to believe in an "equality" of outcome, rather than in one of opportunity; and, in education, that has led to our piecemeal system of credits and marks which divert a student's attention from the structure he cared about, so that "the motivation which was once intrinsic is now extrinsic and superficial." And this established system is hard to overthrow; "for serious administrative [*i.e.*, financial] considerations have made unwelcome any scheme that sacrifices the term-by-term attendance and crediting of students in favor of a decisive final goal with its suspended judgments and inevitable final examinations."

Note here, as we pass, the perfect mixture of "college-minded" motives, unconsciously introduced: to reach an intellectual goal (the "most compelling drive"), to do well on an inevitable final examination, to make a professional success (this is mentioned later), and thus to live happily ever afterwards with one's drives all working together like those of the Irishman who boasted that he was getting ten dollars a day for pulling down a Protestant church. A beautiful synthesis, and fine if you can work it. But who can count on such good fortune? "Philosophy can bake no bread," and there *is* a learned proletariat. Plato played with ideas for the fun of it. Slaves earned his bread and olives.

Now for the tests. Partly for the sake of finding out why so many secondary-school graduates enter college only to fall out by or before the end of the first semester, tests were devised which would reveal "the actual character of a student's intellectual equipment under working conditions, the accuracy and vividness of his ideas, and the areas of his greatest natural aptitudes"; for well-made tests, given unexpectedly, tell far more about the individuals tested than the "credits" they manage to accumulate piecemeal by the proper kind of cramming—and, when given, they actually showed

(among many other things) that a good many freshmen had committed themselves to a course of study in subjects in which they had not done their most effective thinking.

The tests demanded a long series of Yes and No answers to a battery of "significant statements involving the subtler and less obvious relations" in whatever field the student is supposed to have studied. They were prepared by a group of experienced teachers at Columbia and elsewhere, covered what is termed "general culture," and included 1,220 items divided among four broad fields of knowledge: history and related social sciences, general literature other than English, general science, and fine art.

I may add incidentally that such a battery of tests as the commission used is exceedingly difficult to prepare (if the Yes and No answers are to be truly diagnostic) and that with succeeding years the difficulty increases, because it is hard to avoid duplication and students manage somehow or other to supply their fraternity houses with copies of those already given, so that brothers in years to come can give an imitation of effective thinking by cramming up on the answers.

The tests were given to seniors in representative high schools and to sophomores and seniors in many different colleges, with results that leave one wondering what the colleges are doing. When the usual correction had been made for guessing,[1] it was found that the commonest score (out of a possible 1,220) for college seniors was between 300 and 350, while that for the high-school seniors was between 150 and 200. But in both cases there were great differences from the average. The highest college score was over 800; but the lowest was less than 50. And note! Only 4 per cent of the college seniors beat *all* the high-school seniors and only 55 per cent of them beat 90 per cent of the high-school seniors. The best 30 per cent of the high-school seniors outdid the *average* college senior, and much the same results are found in a comparison between college seniors and college freshmen.

[1] With Yes and No answers (in which there are only two alternatives) the scorer's problem is to avoid giving credit for mere guesswork, and he does it by subtracting the number of wrong answers from the number of right and crediting the remainder, on the assumption that the wrong answers are wrong *guesses* and that one *guesses* right about as often as one guesses wrong. This works well enough for all practical purposes when the total numbers are large.

"Here in a nutshell appears the whole absurdity of American college education from an intellectual point of view." At least a third of these graduates from standard colleges "deserve to rank between the ninth and twelfth grade." "So far as knowledge goes, the lower two-fifths of this college group could easily have got out of high school or adult classes all that they got in college." "Their absence would have given college education a completely different meaning for those who were qualified to undertake it."

This is not just a matter of individual students. Another, much more comprehensive, test (including a choice of two out of six languages), given to 4,560 Pennsylvania college seniors in May, 1928, shows great differences between the average scores in forty-nine different institutions. At one extreme, College P gives the A.B. to twenty students who among them average 970, and the degree of B.S. to twenty-six others who average 820. (The upper quarter of its students averaged 1,214.) At the other extreme, College Qq gives the A.B. to sixty-four students who average only 360; and College Kk gives the B.S. to a group of four students whose average is 233. "Judged by the scores of their students, twelve of the forty-nine colleges involved are little better than high schools, and twenty-seven others are on a junior-college level. It is absurd to call them all standard colleges and imagine that they are giving a standard degree."

Dr. Learned is careful to point out that these group comparisons and others contained in the report tell nothing about the peculiarities of individual cases. But he is convinced that it makes a big difference whether an individual is influenced by Alma Mater to think in terms of piecemeal credit or whether "his ultimate career" has begun to glow and he cares increasingly for the elements that will give it substance and interest.

By way of conclusion Dr. Learned says that it looks as if many of the colleges are not really trying to give their students enough confident familiarity with useful knowledge to "make them think." And it is evident that the degrees that they confer are of very unequal value. It would be vastly better for the colleges and fairer to the good students in all of them if the degree ultimately earned were made to depend

not upon the individual colleges at all, but upon a uniform standard examination prepared by some central body.

The significance of this Carnegie Foundation report cannot be ignored, though it may well be misunderstood. Every psychologist knows that some students have vastly more—or less—intelligence than others; and that if the less intelligent happen also to have less health and vigor, less social background and preliminary training, a less happy, sympathetic, and well-regulated home life, less freedom from home duties and other economic responsibilities, and less hope and enthusiasm to spur them on to work, the ultimate difference between these unfortunates and their more fortunate classmates will be enormous. It seems absurd to put one of them in a college "class" as freshman, sophomore, and so forth; to try to build up his "class" spirit; to expect him to take a full schedule of work and class "activities"; and to let him feel disgraced if he can't keep up. And, of course, it is just as absurd to hold back the strong, gifted pupil, with background and no distractions, to an average pace. This, however, is not saying that the less fortunate boy or girl should be kept out of college altogether. Perhaps he needs it more than the more gifted and energetic.

What can be done about it?

As to college degrees, you can't expect Muskrat (I invent the name) or any other college whose students make a poor average showing on standard tests to stop giving its own examinations and conferring the degree which it uses to encourage Tom, Dick, and Harry to come and learn what they can. The study shows that large advances are sometimes made by students in relatively low-grade colleges, and Muskrat may well maintain that it is doing as much for T., D., and H. on *their* level as Harvard is doing for Wendell, Pat, and Solomon on theirs. But it might be a simple matter for the Carnegie Foundation or the American Council of Education or any other such body to prepare a general examination to be given each year immediately after the usual college-commencement season to all graduates who care to take it and then permit those who pass to indicate the fact by adding appropriate letters to their degree—*e.g.*, Harry Dixon, A.B.

Muskrat 1933 (A.C.E. '36). Within Muskrat circles the A.B. will count; beyond them it will be the validating A.C.E.

This does full justice to Harry and puts some pressure on Muskrat and yet leaves it as free as Antioch to try promising educational experiments at its own risk—experiments that some larger and more highly organized institution might hardly care to undertake. Muskrat may have possibilities.

But the problem of education is vastly more important than any problem of degrees; and our story cannot end with the establishment of central validating examinations, however useful they may be in settling the problem of credit for satisfactory work on a standard task. The combination of inward forces on which one must depend for energy to deal with any task differs from man to man; and so one must consider the individual as he is no less than the individual as he is expected ultimately to become. The cumulative-record cards were devised to aid those who are interested in the adaptation of mass methods to the varying needs, capacities, and interests of very different individuals. And when one thinks of all the possibilities, it may well be claimed that the central validating examinations are pretty certain to be confined to a field too narrowly limited by academic tradition to make for the best possible adaptation, especially if the aim of such examinations can be legitimately described in terms of ideas and their skillful manipulation.

We have a right to say to a young physician, chemist, or lawyer: You must know these particular specific facts and the relations between them so well and truly that you can use your knowledge surely and swiftly in any emergency. You must not only "learn to think" (if such a thing be possible), but you must "learn to think" about these particular things. Otherwise you become a public menace. And this applies to all professional training.

The case of amateur scholarship is not so clear. In the good old days when "book learning" had prestige, when people linked the terms gentleman and scholar, and the field of scholarship itself was pretty well defined, the boy or girl exposed to four years of college got "mental training" and "culture" at the same time and from the same material, and

both added to his economic prospects and his social standing. But now there is no recognized magic in Euclid or the classics or the Bible or any other special field. One can get definitely related "ideas" (if that is what we are after) in any field of study, from the trivium and quadrivium all the way down to postage stamps and valentines, the history of the little street around the corner, or the distribution of flies in somebody's stable. From this simple point of view the Iliad and the Odyssey have nothing over Mother Goose and Mickey Mouse. And when it comes to social values, Mickey Mouse may have a distinct advantage. One can always gain perspective and a certain liberation of soul from a knowledge of the past or the distant. Good literature, ancient or modern, gives this and more; it gives companionship beyond the family circle with interesting and worth-while people and something to think about. Mickey Mouse gives something to laugh about; and in an overcrowded era of regimentation, irritation, and family disintegration, companionate laughter may be quite as much the thing as companionate marriage. Our cultural and educational values may need as much reconsideration as our social and economic institutions.

You remember Dr. Learned's description of the "college-minded" pupil, who "stands out at once. When tested without previous warning or preparation, he shows clearly and repeatedly that *ideas* are his field. When presented to him, they stick and grow in his mind," etc.

Beware of metaphors! "Ideas" aren't *things* than can be "presented," "stick," and grow." There *are* no ideas, but only *people thinking,* more or less concretely or abstractly, personally or impersonally, emotionally or unemotionally, impulsively or persistently, playfully or seriously, timorously or courageously, about something that interests them enough to claim attention. And the trouble is that in none of these respects can we draw anything but a very arbitrary line between those who do it satisfactorily (to us!) and those who do not. Those who "stand out at once" are not a separate kind of people, but just extremes.

Most of us find it hard to keep up with mathematical discussions of vectors, tensors, and spinors, though we can think more abstractly than Professor Goddard's feebleminded boy,

who could add and subtract ears of corn, which he was used to counting out for his horse, but couldn't transfer the process to loaves of bread, which he wasn't used to counting at all. In our capacity for abstract thinking, or anything else, we are not grouped at the ends of a scale, but around the middle. The medium sizes are the common sizes; and by the time one supposedly good quality of thinking is balanced against another (*e.g.*, persistence or honesty against originality) it is impossible for any human being to say that this boy or girl should be admitted to college and the one next to him in total score kept out.

And remember, we have been speaking for the moment as if some kind of problem-solving (whether concrete or abstract) were the only valuable kind of thinking. But it isn't. I found to my surprise that I could figure out the right Yes or No to questions on music and fine art which Mr. Tunis quotes in *Scribner's Magazine* for September, 1934,[1] from the study, not because I had ever tried to correlate ideas about them, but simply because I had lived for many years and had heard good music and seen great works of art with one who loved all things artistic. For me this was "experience," "penetrating" enough and vital, as Dr. Learned would have it be, not because it embodied any intellectual endeavor on my part, but because of its purely personal associations. There are some things in life—some "ideas" if you like—that don't have to be built into any structure of hard external relationships to be either remembered or deeply significant, simply because they are sweet and beautiful. Salvation from sordidness is quite as important as salvation from unscientific thinking. *Gaudiamus igitur dum juventes sumus.*

Since college-mindedness is just one phase of human-mindedness, the answer to the question, "Who should go to college?" (the title of a second article by Mr. Tunis, in *Scribner's* for November, 1934) all depends upon what the particular college in question is doing for the whole human beings in it. You cannot isolate intellect and train it alone. One thinks

[1] Mr. Tunis' title is *Human Waste in the Colleges*—the kind of waste that failure in these tests is supposed to reveal. My purpose in this paper is to show that there may be waste of a much more serious kind.

with the whole personality. For, as William McDougall [1] puts it, "all our intellectual structure is built upon a foundation of deep-seated biological urges which, while making themselves felt but obscurely or not at all in consciousness, impel us powerfully towards goals conceived, for the most part, but vaguely and inadequately; and . . . the essential grounds of the great functional disorders of mind are to be sought in failure of these fundamental impulses to coöperate harmoniously in the way which is of the essence of healthy personality."

There is something to be learned about students from rats:

> "An animal must get used to the laboratory conditions before he makes a good subject in a learning experiment. Even the white rat, bred in the laboratory, becomes timid when placed for the first time in a maze or other piece of apparatus. It is standard procedure among animal psychologists to place an animal in some form of maze or similar enclosure for a few minutes every day for a week, and to feed him there, before beginning a maze-learning experiment. This preliminary adaptation enables the animal to make much more rapid progress in learning than if he were taken from his living cage without any preliminaries and started right off in the maze to be learned. During the preliminary adaptation the animal loses his timidity and is ready to explore freely within a similar piece of apparatus.
>
> "Wild rats brought into the laboratory never become thoroughly tame and adapted, at least if they are adult when caught. Placed in a maze, they do not explore at all, even if very hungry. They cower in a corner or run excitedly to and fro. In short their situation-set is the very opposite of that of a tame animal who is adjusted to the laboratory situation and in good condition for learning." [2]

A conventionally "college-minded" student is a good white rat, intelligent, docile (for he won't bite you as the wild rat may), and eager to explore the maze you put him into after the preliminary adaptation of Freshman Week. By a proper balance of tempting cheese and painful shocks, electric or otherwise, you can distract his attention from a purely disinterested and scholarly curiosity about the maze as a whole and teach him various standardized ways of getting out of it in the shortest possible time with all due credit; you can measure his ability to do the stunts you set for him; and

[1] In his introduction to Helge Lundholm's book, *The Manic-Depressive Psychosis*. Durham, N. C.: Duke University Press, 1931.

[2] *Psychology*, by R. S. Woodworth. New York: Henry Holt and Company, 1934. pp. 235–36.

finally, perhaps, you can establish him comfortably and permanently in and about the mazes as an example to others, who may or may not be intelligent enough to follow him by the shortest path through a given maze to the feed-box; for, with human beings as with animals, one test of intelligence is the ability to profit by the experience of others, and the feed-box always counts.

The boy or girl in college who is not "college-minded" may be white and docile enough and yet fail to earn his cheese and later ease because he is just plain stupid, or sick, or fed up and inert, as rats sometimes become. But what if he is neither stupid, sick, nor all fed up, but just a *wild* rat, intelligent enough, but cowering or running excitedly to and fro because he is resentful of captivity, and not at all interested in earning your little bits of cheese through made-to-order stunts in the maze?

If I should ask an animal psychologist why he does not go out after wild rats, coax them kindly into the laboratory, teach them things of lasting value, and then release them to profit by his lessons through all their later life, he would say that I was crazy, for wild rats are not standard laboratory, or shall we say college, "material." Why should *he* know or care "What a Wild Rat Ought to Know"? And, if he did, why should he imagine that the effects of a laboratory training can be transferred to life amongst the garbage cans?

Even the most intelligent of people don't carry many lessons over from one field to another; they don't do much integrating of facts unless they are interested in them; and as the world stands to-day, it is entirely possible to be intelligent and yet not wildly interested, beyond the point of "getting by," in spelling, grammar, punctuation, vocabulary, literature, mathematics, foreign languages, fine arts, history and social studies, or general science (the subjects covered by the Pennsylvania study).

There are fads and fashions in thinking as there are in dressing; and at the moment split infinitives, differential equations, the divisions of all Gaul, pre-Raphaelite Madonnas, and invertebrate anatomy aren't regarded as particularly thrilling subjects of polite conversation. If sex and alcohol have passed out, one can always be serious about the New

Deal, the Second World War, and the coming revolution (to which the wild rats may find themselves quite as well adapted, when, as, and if it comes, as any of our nice, satisfactory white ones); and when it comes to the refined use of leisure in lighter vein, there are always automobiles, airplanes, talkies, radios, night clubs, chain stores, Orphan Annie, and science notes in the newspapers. These and innumerable other socializing interests simply did not exist when present college curricula took shape. The college is still in many respects a pre-war institution in a post-war world. And the very "respectability" of its curriculum may be its greatest limitation. Schools of adult education have this advantage over the colleges that they are less respectable, and fewer of their students seek degrees (which Plato and St. John managed to get along without, apt pupils though they were). They, therefore, have to "sell" their stuff by relating it to the lives and interests of their "prospects," and they cannot dominate their students.

Not only may we be standardizing the wrong cultural material to fit our youth, but outside of professional and semi-professional fields, any standardization whatever has its dangers. "The wind bloweth where it listeth and ye hear the sound thereof; but no man knoweth whence it cometh or whither it goeth. So is every one that is born of the spirit."

I am trying to say that at the present time pure intellectual ability (if there is such a thing) or pure intellectual achievement is hard to test until the factor of interest or motivation is "controlled," because the number of potential interests in or out of college is so great; that the cultural value of these various interests has never been properly appraised, and perhaps never can be, because individual needs are so various; that a college may do harm by cloistering introverts and leading them farther and farther into its mazes and away from the stern realities of the messy world we live in; and that there are spiritual needs which a purely intellectual program of education, with all its instrumentation and studied "objectivity," is bound to ignore. I might add that this spiritual need is all the greater because of the gulf which many college students feel to exist between themselves and their

parents, many of them frankly stating that they "do not speak the same language"!

Then how about the "character education" which Dr. Learned finds some institutions giving or professing to give by way of substitute for exact and solid scholarship?

The difficulty here is even greater than in the case of a purely intellectual program. For what are the youngsters to be taught? And in whose language? Their own or that of their parents? Dr. Learned is surely right in thinking that it gets you nowhere merely to put a lot of emotion behind your own insistence upon old taboos, rituals, blindly accepted customs, and standard ambitions. In Aldous Huxley's naughty *Brave New World* that sort of thing is taken care of by phonograph speakers under the pillows of sleeping children, who thus get the catch words pounded into "the subconscious" and always act accordingly in a properly stratified and biologically standarized society, which has been carefully prearranged for their benefit. The book leaves you with this dilemma: Fertilize and standardize the bodies of all human embryos in test tubes and then standardize their minds in public nurseries, or else get killed off for good and all in a new Armageddon. But the escape seems rather worse than the catastrophe. The brave new world is *cheap*. Character isn't made that way, and stratification and standardization are as far from genuine socialization as the Law is from the Gospel.

In the *Virginia Quarterly Review* for July 1934, Professor Robert C. Binkley contends that each age has its own peculiar conception of human nature, which determines its estimate of values. The eighteenth century was the age of Rousseau, with all men equal participants in a common *reason* which must alone guide our path. Hence democracy and voting, not as a balance of interests, but as a means for finding and expressing this universe *sensus communis*. The nineteenth was the century of Darwin, in which the machine and mechanical laws were everything, from the factory and the "economic man" to a mechanistic theory of evolution and an equally mechanistic theory of government. For was it not Great Britain's admirable and imitable special parliamen-

tary system that kept her people free? If we see now that that or any other special machinery cannot be relied upon, it is because we already have still another conception of human nature. Professor Binkley calls our present age "the century of Freud and of the Intelligence Test." He might have added Relativity.

We have seen that if we look at non-professional education from the standpoint of intelligence tests and the vast differences of capacity that they reveal, we must give up our efforts to get a standardized product—efforts that keep our most gifted students bored and stultified and our least gifted overstrained and defeated; unless indeed the standardization has a social value far outweighing the harm that it does to individuals. Professor Leta Hollingworth says that true educational democracy means giving each individual a chance to achieve his own particular best—no matter where that may lie along a general scale.

This democracy without standardization is a good human example of relativity. If we know the new physics, we will not expect a clock on a swiftly moving comet to keep time with its twin clock on earth. There isn't even an identical NOW for all the universe. Yet somehow all the bodies, large and small, in the great space-time continuum have real and calculable dynamic relations to one another, and the conflicting reports of earthly and astral astronomers can be made to agree exactly if both will make the corrections necessary to get away from a purely local point of view. So with education. A moron and a genius do not move at the same pace; they hardly speak the same language; and any specific schoolroom routine worked out for the one is sure to hamper the other. Yet fundamentally they are alike, for both strive to reach a certain fulfillment of human possibilities—to grow and enrich their lives, to be in some way effective, to be appreciated and understood, and thus in some way or other to "belong." Thus both obey the same larger laws, and they can work together in mutual happiness. This relativistic point of view is the beginning of successful intellectual education—and it applies as well to morals.

Kant, like the writer of the Ten Commandments, conceived of morals as absolute or categorical, universal, and in

some way imposed. "So act," said Kant, "that the maxim of your conduct may become a principle of universal legislation." And until quite recently this conception prevailed:

> "For right is right, since God is God,
> And right is sure to win.
> To doubt would be disloyalty,
> To falter would be sin."

A child or a small-town moralist can tell you exactly what it is that is right and therefore approved by God and sure to win; and he does not hesitate to regulate his neighbors and to pass judgment on those who violate the code he knows—until perhaps he learns something intimate about the ways of Russia, Italy, Samoa, Japan, or even his neighbor across the road, when it may occur to him that morals do not have to be either uniform or imposed, because man everywhere is trying to bungle his way toward a fulfillment of life, which (whether one quite knows it or not) must necessarily include in some way the well-being of other people; that the Kingdom of Heaven which every one seeks is to be found for the most part within oneself; that the greatest obstacles in one's way are also often within one, and that therefore this business of imposing laws on others is not so good! Better perhaps to start with each man where he is, help him to find a genuine task into which he can throw himself with interest, and then to clear away the inward obstacles and misconceptions that keep him from reaching in his own way the growth or fulfillment which he glimpses and which nothing can keep him from wanting. You need no rod to drive him on. There is plenty of urge within him. He only wants a chance to do something useful and interesting and an inward release. Something, then, like this is a relativistic or universal point of view to which all specific codes or customs may be reduced—a supreme urge to grow and achieve, a task through which to meet the world, and freedom without and within to integrate one's life about it.

If this is the century of Freud, it is because Freud recognized the importance of inner adjustment as well as external adaptation and gave us a technique for bringing it about. Sane psychoanalysis must always be for the sake of a surer psychosynthesis. And we have faith to believe that the man

who has learned to "rule his own spirit" will have no mad desire to crash traffic lights or to "take a city." He is above the law and needs no watching.

And so at last we leave all the machinery of mass production and mass inspection behind us and come face to face with the individual where he is—at his job if that is where he wants to meet us, or far, far from it if he is bored and looking for relief. If he is sick of drudgery and comes to us for escape, we will not pile more of it on him. If he is economically insecure, the work we offer him ought to promise the beginnings of a livelihood. If he is isolated, it should offer him companionship; if he is bored, interest. If he feels inefficient and inadequate, it should offer him efficiency and adequacy. If he has to compensate for supposed inferiority, it should give him a chance to show his worth. If he is inarticulate, it should offer him speech. If he is sick or flabby, it should help to build up his physique. If he is "groping, leaderless, and blind," we should find him leadership and some glorious vision of a city set on an hill. If he is negativistic, we should give him respect and understanding; and if he, or rather she, should care to build her life around homey, household arts, we should recognize the dignity of her aspiration. One must be all things to all men and give each individual a chance to integrate life as he—or she—can, offering friendly understanding or enlightening suggestion to all and domineering over none. It is hard enough at best for any one to define his aims and find his way. And it is vastly harder when he is continually hampered by the blind categorical imperatives and meticulous rules of academic masters and mistresses who see conventional educational products, but not the inward joy or agony of the producers. The League of Nations has, I think, declared that "labor is not a commodity." Perhaps in the last analysis education is not either.

But remember! There is nothing absolute about the change from century to century or age to age. New insights do not supplant old values. They should suffuse them. There is still a rule of reason, at least as an ideal. There are still economic laws, a fierce struggle for existence, machinery, measurement, organization, and mass production. Existing institutions, with all their faults, are packed with values. No sane person

wants to destroy them or to wipe out the cultural elements in education that tie us to the past and make life beautiful and dignified at least in spots. The essence of a liberal education is the achievement of high spiritual freedom in a world of reality. And that is hopelessly misunderstood if it is taken to mean that there should not be enough everyday rules or traditions in a college to keep things running steadily with reasonable economy, or that youngsters should not be trained to the habits of industry and efficiency which themselves make for freedom. Nor does it mean that they should be without the firm hand which they really want to help them in their self-discipline, or the authority which is sometimes needed to keep the blind and reckless from leading their fellows into the ditch. Young people do not resent authority, though they do resent pettifogging. And they know they need something or some one to revere, and the sense of safety which that very reverence brings. The more habits of critical detachment they have learned in the classroom, and the more everything in the world outside seems to whirl and topple, the more they need the deep abiding sense, which serene and wise maturity can give, of something firm beneath it all, and of a human solidarity vastly deeper than the frothy companionship of cocktails.

Serene and wise maturity, however, it not just a matter of years. It is a matter of insight. You cannot give lasting reassurance and wise guidance to any one unless you understand him and his fundamental problems, as well as the world which he has to meet. This is no superficial business. And however much a college may insist on its own particular fields of study and standards of scholarship, it is important that those charged with the guidance and discipline of its students should know at least as much about the fundamentals of human nature and the technique of securing inward harmony and sound adjustment habits as the physician in charge of a child-guidance clinic or the bright assistant in a nursery school.

READING DISABILITIES IN RELATION TO DIFFICULTIES OF PERSONALITY AND EMOTIONAL DEVELOPMENT*

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IN this paper, an attempt will be made to summarize some of the material accumulated in clinical work with patients who had trouble in learning to read, and to describe the point of view that has grown out of this experience. Since the material includes data from the psychological-testing, social-case-work, and psychiatric approaches, as well as from those of remedial teaching and treatment of a psychotherapeutic nature, both statistical and case-report methods will be used in presenting it.

Data from Psychological Tests.—The results of the testing in 73 consecutive cases, seen at the clinic from 1925 to 1932, were tabulated in 1933, but have not hitherto been published. Of these 73 cases, 63 boys and 10 girls, trouble in learning to read was one of the reasons for referring the case in 42 instances; in the other 31 cases the reading disability was noted during the clinic study, the reasons for reference being given as poor school progress, personality maladjustments, behavior problems, or request for educational guidance. Even in the 42 cases in which a reading disability had been mentioned at the time of reference, there were frequently personality or behavior difficulties which were regarded as more important in sending the child to the clinic.

The ages of the 73 children ranged from six and a half to sixteen years. In school placement, they were scattered through the elementary and junior-high-school grades, with one senior-high-school student. There were nine children not in regular grade—two who were having individual work in private schools, and seven in public-school classes for men-

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tally deficient or behavior-problem pupils. The details of age and grade distribution are given in Table I.

Intelligence tests were given to all but one child, who had been tested elsewhere just before being referred to the clinic and diagnosed as "low average." More than half of the group rated as average—I.Q. 90–109; almost a third were of superior intelligence—I.Q. 110–139; the rest were below average—I.Q. 70–89, but in no case did the I.Q. fall below 70. It is evident that mental deficiency was not a factor in this

TABLE I.—DISTRIBUTION OF 73 CASES OF READING DISABILITY BY AGE AND GRADE

Age	*Cases*	*Grade*	*Cases*
6½ years to 7 years, 11 months	13	First	12
8 years to 8 years, 11 months	15	Second	10
9 years to 9 years, 11 months	12	Third	16
10 years to 10 years, 11 months	10	Fourth	11
11 years to 11 years, 11 months	10	Fifth	6
12 years to 12 years, 11 months	6	Sixth	4
13 years to 13 years, 11 months	3	Seventh	2
14 years to 14 years, 11 months	0	Eighth	1
15 years to 15 years, 11 months	3	Ninth	1
16 years to 16 years, 11 months	1	Tenth	1
		Not in regular grade	9
Total	73	Total	73

group of cases. The distribution of intelligence quotients for the 72 cases tested at our clinic appears in Table II.

Excluding the nine children not in regular grades and the one child tested elsewhere for whom we had no mental age, there were 63 whose grade placement could be compared with norms for age-grade and mental-age-grade placement. Without reproducing the tables giving these data in detail, the findings may be briefly summarized: Eight children were graded from one to two years above age; 24 were from one to two years retarded for their age; 31 were placed within a half year of their age. With respect to mental-age-grade placement, five were from one to two years above mental age; 27 were within a half year of mental age; 29 were in grades from one to two years below mental age; while one child was three and another four years retarded for mental age. The seven children in special classes in the public schools had presumably been placed there because of their

reading disability or behavior, since none of them had an I.Q. below 80. Thus, out of the whole group of 73 children, 31 were either below grade for age or in special classes, while 36—about half of them—were below grade for mental age or in special class. This retardation in school progress would be expected for children handicapped in reading, for other investigators have shown that trouble with this subject is a frequent cause of failure to be promoted, especially in the lower grades.[1]

TABLE II.—DISTRIBUTION OF 72 CASES OF READING DISABILITY BY INTELLIGENCE QUOTIENTS

I.Q.	*Cases*
70– 79	2
80– 89	7
90– 99	18
100–109	22
110–119	16
120–129	6
130–139	1
Total	72

Except for 16 primary-grade children, who could recognize almost no words and could be called practically non-readers, each child was given more than one reading achievement test. These tests were selected for the individual case on the basis of suitability to age, grade placement, and reading skill as indicated by the Gray oral-reading test, which was the first to be given. The scores for the reading achievement tests most frequently used, in comparison with mental age and school grade, are shown in Table III. It may be seen from this table that although a few of the children were within a half year of mental age or school grade, most of them had scores from one to six years below their mental ability and grade placement. The diagnosis of reading disability, for the 31 cases in which this had not been mentioned when they were referred to the clinic, was made because of their low scores on the reading achievement tests.

[1] See, for instance, *The Improvement of Reading*, by A. I. Gates. New York: The Macmillan Company, 1927.

TABLE III.—ACHIEVEMENT OF READING-DISABILITY CASES ON READING TESTS FOR MENTAL AGE AND SCHOOL GRADE

	Achievement for mental age				*Achievement for school grade* *			
Test	Number tested	Within ½ year of mental age	1-1½ year below mental age	2-6 years below mental age	Number tested	Within ½ year of school grade	1-1½ year below school grade	2-6 years below school grade
Gray oral	59	0	12	47	52	2	19	31
Gates primary:								
Type 1	40	8	15	17	37	11	19	7
Type 2	35	2	14	19	32	6	19	7
Type 3	18	0	7	11	16	1	8	7
Monroe silent:								
Rate	18	0	2	16	13	1	2	10
Comprehension	18	2	2	14	13	2	5	6
Sangren-Woody:								
Word meaning	10	1	4	5	9	1	3	5
Rate	10	1	1	8	9	1	0	8
Facts	10	0	1	9	9	0	1	8
Total meaning	10	0	2	8	9	0	5	4
Central thought	10	0	3	7	9	1	5	3
Directions	10	0	1	9	9	1	2	6

* Figures in this part of the table exclude the cases not in regular grades.

In 53 of the cases, tests in other school subjects were given. Next to reading, spelling was the subject in which poor achievement was most frequent. The best subject was arithmetic fundamentals, in which the achievement was in such marked contrast to that for reading that it seems worth while to report the results of the arithmetic-fundamentals tests for mental age and school grade, in Table IV. Comparing this table with Table III, on the reading tests, it will be seen that while most of the children were below mental age and grade in reading, on tests of arithmetic fundamentals about two-thirds of those tested were above or within a half year of mental age and grade. Presumably the reason for these comparatively high scores in arithmetic fundamentals is the fact that this subject is least dependent upon proficiency in reading for its mastery.

TABLE IV.—ACHIEVEMENT OF 53 READING-DISABILITY CASES IN ARITHMETIC FUNDAMENTALS FOR MENTAL AGE AND SCHOOL GRADE

Achievement for mental age	*Cases*	*Achievement for school grade*	*Cases*
Above mental age	7	Above grade	14
Within one-half year of mental age	28	Within one-half year of grade	25
One year below mental age	9	One year below grade	4
One and one-half years below mental age	4	One and one-half years below grade	2
Two years below mental age	5	Two years below grade	1
		Not in regular grade	7
Total	53	Total	53

Tabulations of data from diagnostic tests are omitted in order to conserve space. The diagnostic testing varied with individual cases, the selection of particular tests being determined partly by the child's age, grade, and reading skill, and partly by the amount of time that could be used for testing and the availability of test materials. The Orton-Monroe tests, for instance, were not available during the first years of clinical work with reading disabilities and were given to only 24 children of the group tested in the later years. In order to avoid too much scattering of small numbers, the findings from the diagnostic tests are summarized mostly in terms of difficulty or no difficulty, rather than by the age and grade norms in which the Gates tests were scored, or by the

degrees of difficulty for grade in which the Orton-Monroe tests were scored originally.[1]

Of 40 younger children given the Gates A-3 test for visual perception and discrimination of words, 35 showed difficulty and only 5 no difficulty. Of 32 older children given the Gates B-2 test for word discrimination, 25 had difficulty and only 7 no difficulty. Thus it appears that nearly all the children in the group of 73 had difficulty in discriminating between words that look similar to one another.[2] Of 49 children given the Gates word-pronunciation test, all had faulty methods of word recognition of one kind or another. In 22 cases there was lack of knowledge of phonetic sounds for single letters and combinations of letters; spelling out words was the method of attack used by 12 children; 10 guessed at words from one or two of the letters, and 5 treated words as "phonetic puzzles." None of the children given the Gates word-pronunciation test made scores in keeping with mental age or grade in school.

Even before the Orton-Monroe tests were available, we were familiar with Orton's theories of reading disabilities and the relation of confusions of certain letters, or of tendencies to the reversal of letters and word sequences, to trouble in reading. We had, therefore, been alert to detect such manifestations in our cases in observations during the Gray oral-reading and the Gates word-pronunciation tests. We found six children who confused letters and 15 who reversed letter sequences on these tests. In the 24 later cases given the Orton-Monroe diagnostic tests, 10 reversed sequences on the Iota word list, while the test for confusion of letters showed six who had this difficulty. Combining the observations from the Gates and the Gray tests with the findings from the Orton-Monroe, we had altogether 25 cases with

[1] The original scoring was according to the tables of norms in *The Improvement of Reading* for the Gates tests, and for the Orton-Monroe tests, according to tables in *Methods for Diagnosis and Treatment of Cases of Reading Disability*, by Marion Monroe. (Worcester, Mass.: Clark University Press, 1928.)

[2] Thirty-seven of the 40 children given the Gates A-3 test also had the A-1 and A-2 tests of the series. Only 13 had difficulty on the A-1 (concrete material); 20 had difficulty on the A-2 (digits and numbers). The visual perception and discrimination were better for other types of visual material than for words, to judge from these figures.

a tendency to reversals, and 12 with a tendency to confuse letters, such as b and d, p and q, and so forth. It may be mentioned in passing that the 16 children who had been changed from left- to right-handedness showed no strikingly greater difficulties as to confusions of letters or reversals than those who had always been right-handed.

In general, then, the diagnostic tests showed that almost all the children in our group of 73 had trouble in discriminating between words that look somewhat alike; about one-third had tendencies to reversal; about two-thirds had faulty methods of word recognition. In individual cases, the value of the diagnostic findings lay, of course, in their bearing upon the planning of remedial-teaching methods adapted to overcoming the particular form of difficulty in question. We have summarized above the findings from the tests that were given to the largest number of cases, omitting those that were used less frequently. Perhaps the most interesting finding, so far as concerns the results of the diagnostic tests for the whole group, is the greater frequency of such difficulties as Gates has stressed than of the difficulties stressed by Orton in his earlier writings. With a group of only 73 cases, however, it may not be statistically permissible to attach too much significance to this fact.

The disproportion of the two sexes among reading-disability cases is greater than for clinic cases as a whole. In the group of 73 for which test data have been reported, all but 10, or approximately 86 per cent, were boys; of the total number of 2,355 cases seen at the clinic during the same years, approximately 65 per cent were boys. Monroe's studies also indicate that boys have trouble with reading more frequently than girls.[1]

Remedial Teaching.—Remedial teaching, which was our

[1] In Monroe's *Methods for Diagnosis and Treatment of Cases of Reading Disability*, she states (p. 367), that 77.1 per cent of her group of 175 retarded readers were boys, while only 52.5 per cent of her normal reading controls were male. In a later study of reading disabilities, she found that of 5,000 cases of all types at the Institute for Juvenile Research, 62 per cent were boys; of 215 reading-defect cases at that clinic, 84 per cent were boys; of 155 special cases of reading defect, 86 per cent were boys. (See her *Children Who Cannot Read.* Chicago: University of Chicago Press, 1932. p. 98.) In this connection, see also "Sex Differences in Speed of Reading," by Isabel Berman and Charles Bird. *Journal of Applied Psychology*, Vol. 7, pp. 221-26, June, 1933.

first approach to reading-disability cases, often gave successful results, as illustrated by the two case summaries that follow.

Case 1.—This boy was referred to the Los Angeles Child Guidance Clinic in 1924. He had had a vision defect, described as "seeing double," which was not discovered and corrected until he was eleven years of age. The correction of the visual defect did not enable him to overcome faulty habits of reading which he had previously established. He had been placed in an "opportunity" class, with pupils who were mentally retarded or backward educationally for other reasons, and had been three years in this class when referred to the clinic at the age of thirteen.

The Stanford-Binet gave him an I.Q. of 118. On the Thorndike-McCall reading scale, his score was 9 years, 2 months—six and a half years below his mental age. He made the same score in spelling. He could do seventh-grade arithmetic, however, and was fairly good in history, which he had learned by having his sister read it aloud to him. At that time, the Gates diagnostic reading tests were not available, and the diagnostic tests used were those described by C. T. Gray in *Deficiencies in Reading Ability.*[1] They showed a short span of visual perception, poor visual-verbal vocabulary, and poor visual-verbal memory. On the other hand, they showed also rapid vocal-motor reactions, extensive auditory-verbal vocabulary, and superior auditory-verbal memory. The boy's prime interest in reading material was its meaning; when reading orally, he frequently substituted synonyms for words he was unable to recognize, supplying the meaning correctly from the context, though he did not guess the particular word.

Although he had developed some feeling of inferiority in reaction to his failure in school, he had found compensatory satisfactions. He was proud of his mechanical skill and of his success with a paper route, which he had conducted so well that he had accumulated a small bank account from it.

We were fortunate in securing for this boy the services of Mrs. Keller, who, in collaboration with Dr. Grace Fernald, had originated a remedial-teaching method. The boy was transferred to the school where Mrs. Keller taught, and had arithmetic and history with the seventh-grade students, geography and language with the sixth grade, and individual work in reading and spelling with Mrs. Keller.[2] Six months later, the boy was given the Stanford Achievement Test. From the former score of 9 years, 2 months in reading and spelling, he had improved to 12 years, 2 months in reading and to 11 years, 1 month in spelling. He had also improved in other subjects.[3]

Reports of the boy's progress thereafter were received in letters from

[1] Published by D. C. Heath, 1922.

[2] For her remedial-teaching methods, see "The Effect of Kinæsthetic Factors in the Development of Word Recognition in the Case of Non-Readers," by Grace M. Fernald and Helen Keller. *Journal of Educational Research*, Vol. 4, pp. 355–77, December, 1921.

[3] A report of the case, up to this point, was given earlier in *Reading Disabilities in Relation to Maladjustments*, by Phyllis Blanchard. MENTAL HYGIENE, Vol. 12, pp. 772–78, October, 1928.

him or his sister. He completed high school in the usual length of time and entered college, taking an agricultural course. His last communication was an invitation to the commencement exercises, upon the occasion of his graduation from college.

Case 2.—A ten-year-old boy, who was repeating low third grade, was referred to the Philadelphia clinic because of trouble with reading and spelling. He had skipped high second grade, but began to have trouble with reading thereafter. During his first term in low third grade, he had a very critical teacher, who called him stupid and crazy; he misbehaved while in her class. At the time he was referred to the clinic, however, he had a teacher whom he liked and no personality or behavior difficulties were noted.

According to the tests, he had an I.Q. of 100, his achievement in reading was two years below his mental age and a year below his school grade, his methods of word recognition were entirely inadequate, and he confused words that looked alike. Although he had been changed from left to right hand before entering school, the Orton-Monroe tests revealed no confusions in orientation and little tendency to reversals.

He started coming to the clinic, in January, 1931, for remedial teaching two hours a week. The remedial teaching continued until the summer vacation; it was resumed in October, 1931, and ended finally in May, 1932. Altogether, the boy came fairly regularly for the remedial lessons for a first period of six months and, after two months' vacation, for a second period of eight months. He was promoted regularly durthis time, and his achievement on reading tests was within a half year of his school grade at the time remedial teaching was terminated.

In the remedial teaching, games and exercises for improving word recognition and discrimination of words, as suggested by Gates in *The Improvement of Reading*, were used to supplement the readers and work books of the *Work-Play Series*.[1] There were some modifications and variations of methods in keeping with interests expressed by the boy; for instance, when he wanted to learn to use a typewriter, the typing was combined with exercises for improving word recognition and spelling of words, and so forth.

The boy returned for visits, of his own accord, on three occasions after the teaching was completed. He came once in November, 1932, to tell of having been promoted the preceding June and of getting good marks on his reports in high fifth grade. Nothing more was heard from him until January, 1934, when he made a visit to announce that he was ready to enter junior high the next term of school. He returned in April, 1935, to report that he would graduate from junior high in June and to discuss the problem of whether to continue school or to leave school to work, in order to contribute to the family income, which had been greatly reduced. He reached a decision to go to senior high through considering the realistic aspects of the problem—the difficulty of finding a job and the probability of wages too low to help his family much—and through clarifying some of his conflicting feelings as to whether it was his duty to give up further education in an attempt to ease his mother's economic troubles or whether he could stay in school without too much guilt.

[1] These readers, by Gates and Huber, are published by Macmillan.

There may be a question as to how much success depends upon the special methods of instruction employed and how much it is due to other factors inherent in the situation and the relationship. In the individual teaching situation, the child is removed from discouraging competition with others who are more proficient in reading. Still more important, probably, is the relationship with the person who assumes the rôle of teacher. This individual teaching relationship is somewhat different from the teacher-pupil relationship with a group of children; it may favor the development of a strong positive "transference" to the adult who acts as teacher. If such positive response is developed, it naturally increases the child's effort and energy in the learning task, since he wishes to please the person whom he likes.

In the two cases used as illustrations, neither child seemed to have very serious problems of personality or emotional development, so far as can be judged. Both had bad starts in school—the first because of an undiscovered vision defect, the second because of skipping a half year, missing some of the early instruction in the fundamentals of reading thereby and at the same time encountering a teacher with whom he came into conflict.

Transition to Therapy.—Not all of our early reading-disability cases responded as well to remedial teaching as the two that have been reported. It was observed that very often those who did not respond to tutoring seemed to have emotional conflicts, as well as the trouble with reading. After therapeutic techniques had been developed in the direct treatment of children with personality and behavior difficulties or neurotic symptoms, we began to experiment with similar therapeutic procedures in some cases of reading disability in which emotional problems also were present.[1]

At about the same time, the kind of reading-disability cases referred to the clinic began to change. With a permeation of knowledge of diagnostic-testing and remedial-teaching methods into the schools, the children referred for read-

[1] For brief descriptions of treatment techniques with children in the Philadelphia clinic, see "Therapeutic Work with Children," by Frederick H. Allen, M.D. and "Treatment of Children in a Clinic," by Phyllis Blanchard, both in Chapter I of *Readings in Mental Hygiene*, edited by Ernest R. Groves and Phyllis Blanchard. New York: Henry Holt and Company, 1936.

ing disabilities were often those who had already failed to respond to remedial teaching. Certain of these cases were described as having such pronounced personality difficulties or neurotic symptoms, in addition to the trouble with reading, that it was easy to see from the beginning that a therapeutic rather than an educational approach was necessary. But others at first seemed to be fairly well adjusted socially. In the tutoring situation, with the new insight gained from experience in treatment, it soon became apparent that underneath a superficial social adjustment, many of these children were burdened with emotional conflicts that made response to teaching impossible and indicated the need of therapy. An illustration of this type of case follows.

Case 3.—An eleven-year-old boy, in fifth grade, was referred to the clinic because of trouble with reading. He was considered well adjusted otherwise—he had many friends and joined in athletic activities and games. The only trait suggestive of possible emotional difficulties was a tendency, noted by his mother, to be reserved and reticent about his thoughts and feelings. Significant features of his pre-school history were an early and difficult weaning; a period, when he was between three and four years of age, of being left in the care of a grandmother while his mother was working; an operation of the mother's when he was five years old. After he started school, his mother returned to work. It was not easy at the beginning of the case to evaluate the importance of these events in his early life as compared with those of his school history. He had been transferred from one school to another at the end of first grade, had repeated first grade in the second school, and had had marked trouble with reading in second grade, which persisted thereafter in spite of some attempts at individual tutoring by several teachers.

Psychological tests gave a picture of a boy of normal intelligence, with reading achievement about three years below his mental age and four years below his school grade, and with inadequate methods of word recognition together with a marked tendency to confuse words that looked somewhat alike. In two informal interviews, he talked of his interest in athletics, in mechanical construction, in radio, and in drawing; on tests of mechanical aptitude and of artistic talent, he did very well. He believed that his trouble with reading was due to his having had three different teachers in second grade and to lack of continuity and regularity of tutoring. He felt sure that he could learn to read with regular tutoring and was eager to come to the clinic for this purpose.

His reactions while reading soon revealed underlying emotional conflicts. He would be reading a story fairly well, then would suddenly begin to confuse words, be unable to recognize words that he had been reading correctly, and make all kinds of errors. Soon he would stop reading, and begin to tell a story that had as its starting point some episode of which he had been reading at the moment he began to make

mistakes. Usually the story would go on into some phantasy of his own, in telling which he would be absorbed until it was finished. He would then be able to resume reading fairly well again. Thus it was obvious that while the boy was handicapped in reading by deficiencies revealed in the testing, he was even more hindered because certain passages in the material that he encountered served to evoke a train of associations from his unconscious, concerned with some of his repressed emotions, with a resulting breakdown of what reading skill he did possess as his attention was diverted by the emergence of these unconscious phantasies.

Samples of these phantasies may be given. A story of a bad dog evoked associations to the effect that once he had had a dog which he loved very much, but could not keep. He had cried and cried because he had had to let his dog go to live with other people. He would rather have had it killed, for if it had died, he could have continued to think of it as his own instead of having to think of it as happy with other people and giving them the affection it once had given him. This phantasy seemed analogous to what he might have felt regarding his mother's leaving him to work; in later treatment interviews he talked more directly about his feelings with regard to her being so much away from home.

Another story, about squirrels, elicited a phantasy that he had had a pet squirrel which could not nurse its babies; they nearly starved and the mother squirrel died. He elaborated that one of the baby squirrels still lived near his home; he could recognize it because he had marked it by tying a string around its paw. Later, in treatment, he talked about his mother's having told him of his difficult experiences at weaning, when she had not been able to continue nursing him. Also she had told him how, in the hospital at his birth, she had scratched a mark around his wrist to be sure that she would not get some other baby in his place.

In these and other phantasies which appeared in association to reading material, there was evidence of his repressed hostility, ambivalence, and guilt. Therefore, after a short period of remedial teaching, this was discontinued and a change to therapeutic interviews was made. In the treatment interviews, his ambivalent feelings of love and hostility toward both parents, and his guilt over the hostility, were expressed in the transference relationship to the therapist. He also gave more details concerning the beginning of his reading disability, when he was in second grade. He had done well with his first second-grade teacher, but she had become ill and gone to the hospital for an operation. She had never returned and he felt sure that she had died. (Checking with the school revealed that actually the teacher had recovered, though perhaps the pupils had not known what happened to her.) He had liked this teacher, had worried about her being in the hospital, and had not seemed to be able to keep his mind on his work with the two succeeding teachers in second grade.

He was unable to remember, during the incomplete period of treatment, that his mother had once been ill and had had an operation. To judge from his phantasy that the teacher had died from her operation, the memory of his mother's operation had been repressed because of death wishes toward her associated with it. Such death wishes were un-

acceptable to him, because he also loved his mother very much. It would seem that the teacher's illness partially reactivated the earlier emotional conflict surrounding his mother's illness, so that energy which might otherwise have been available for learning to read had to be expended in maintaining repression of memories and emotions, as they threatened to break through into consciousness and aroused anxiety and guilt. The boy's mother broke off his appointments at the clinic after thirty-five visits (first for remedial teaching and afterward for therapeutic interviews) before the treatment was fully completed. Her work had interfered with regular appointments for herself with a social worker, so that her reactions to the boy's relationship to the therapist could not be met as part of the case-work, and this was undoubtedly a factor in her unwillingness to permit the boy to continue.

Besides illustrating how feelings may interfere with attention and concentration while reading, this case also illustrates the difficulties of a change in method during the course of clinic contacts. Besides the mother's difficulty in regard to the boy's relationship to the therapist, without help from a social worker, she also was puzzled by the change from remedial teaching to the therapeutic approach. On the whole, it seems easier for children to accept the idea that their feelings are interfering with their learning to read, that tutoring is less likely to help them than straightening out confused feelings, than for parents to believe that what seems to be primarily an educational problem can be helped by other than educational methods. If the question of treatment is introduced at the beginning of the case, rather than later, the parent has more opportunity to participate in this plan, in deciding whether to make use of the clinic.[1]

The unconscious wish of the parent to see a child's difficulty with reading as primarily educational rather than emotional is not hard to understand. The former implies a problem in the child's relationship to the school; the latter may lead to the parent's beginning to question his own relationship to the child and the need to do something about it.

Treatment.—As has been implied, we have become convinced that for children referred after unfavorable response to remedial teaching at school, or for cases in which neurotic symptoms or personality and behavior difficulties are present, a therapeutic approach is more suitable than an educational

[1]For discussion relevant to this point, see "Treatment Possibilities in the Application Interview," by Almena Dawley, Chapter XIV of *Readings in Mental Hygiene.*

one. From these treatment cases, during the last three years, we are beginning to see something of the deeper relations between emotional problems and reading disabilities. Like other investigators, we had previously been aware of certain emotional aspects, such as attitudes unfavorable to reading, or personality and behavior difficulties either coexistent with the reading disability or in reaction to it.[1] But it is only from the material produced by patients in treatment interviews that reading disabilities appear very clearly, in many instances, as a part of a more general difficulty in achieving normal emotional growth. While we do not claim that trouble with reading is invariably of this origin, our experience does lead us to believe that it is related to difficulties in emotional development more frequently than has hitherto been realized.

Certain of our treatment cases have been reported very briefly in a previous paper.[2] A case that also has been summarized more fully elsewhere is reported here, in brief, because of the clarity with which the child spontaneously described the feelings associated with his inability to read and spell words.[3]

> *Case 4.*—The boy in this case was an illegitimate child whose mother deserted him after giving birth to a second illegitimate baby, a girl, when he was three years old. He was placed with a foster mother, to whom he at once became attached, but after a year with her, he had to be moved to a second foster home because she became too ill to keep him. He reacted to these two successive losses—of his own mother and

[1] As early as 1925, Orton had described four types of emotional response to reading disabilities and the resultant school failure. (See "Word-Blindness in School Children," by S. T. Orton. *Archives of Neurology and Psychiatry*, Vol. 14, pp. 581-615, November, 1925.) Elizabeth Hincks, in a monograph, *Disability in Reading and Its Relation to Personality* (Harvard University Press, 1926), noted nervous symptoms and personality problems in reporting 13 cases. Gates, in *The Improvement of Reading* (pp. 312–16), described emotional factors that interfered with learning to read in certain of his cases. Some of our own earlier observations were reported in *Attitudes and Educational Disabilities*, by Phyllis Blanchard. MENTAL HYGIENE, Vol. 13, pp. 550–63, July, 1929.

[2] "Psychogenic Factors in Some Cases of Reading Disability," by Phyllis Blanchard. *American Journal of Orthopsychiatry*, Vol. 5, pp. 361–74, October, 1935.

[3] This case is reported, in more detail, in *Readings in Mental Hygiene*, Chapter VIII: "Emotional Factors in a Case of Disability for Reading and Writing Words," by Phyllis Blanchard.

the first foster mother—by an extreme infantile regression, losing bladder and bowel control, developing a speech defect, and so forth. When he entered school, he was sent to a speech class and his speech improved. He could not learn to read, however, and remained in the low first grade, being still there without ever having been promoted when referred to the clinic at the age of eight years. He had not learned to write correctly, his efforts to write words being characterized by reversals of letters and sequence, misspellings, or making peculiar marks instead of writing. Before the infantile regression, when he was with the first foster mother, he had tested at I.Q. 95; after the regression, tests at the age of five and seven gave him, respectively, I.Q. 76 and 74.

When referred to the clinic in April, 1934, he was still wetting and soiling himself, was overactive and inattentive in the classroom, had no friends and never played with other children, and seemed withdrawn from reality and living in a phantasy world of his own. With such a description, it was evident that treatment rather than remedial teaching was necessary. The treatment, with interviews at first once a week, then twice weekly, with breaks due to summer vacations, lasted until November, 1935, during which time he had a total of 110 interviews. This comparatively long time of treatment, for a crowded clinic schedule, was necessary because of the severity of his emotional and personality problems and the depth of anxiety and guilt that he had to overcome. However, not much more time was required for treatment in this case than for the remedial teaching in Case 2. During the time he was being treated, he was promoted regularly, his wetting and soiling cleared up, and he became well adjusted socially in relation to other children, as well as gaining contact with reality.

At the beginning of treatment, the boy could not even draw or color or cut out pictures as well as the usual kindergarten pupil. His conversation was largely an expression of wish-fulfillment phantasies of being big and strong and able to do everything well. His difficulties were denied and projected onto the therapist; if reality interfered with his wish-fulfillment phantasies, he reacted with anxiety and rage. Thus, if he failed to draw a picture as he planned, he would accuse the therapist of spoiling it, and even would insist that she was the one who could not read or write. These projections were given up gradually, as he gained security in the treatment relationship, and he then began to admit his difficulties and to wish help in treatment.

The phantasy of being big and strong—a grown-up man like a father—was related to his having heard that his mother had married, after leaving him; he imagined that one reason for her desertion might be that she loved a big man who could be her husband, but not a little boy who was a son. This imaginary idea was transferred to his foster mother and to the therapist, both of whom, at times, he accused of caring nothing for him and loving only their husbands.

He had many other imaginary explanations of his mother's desertion. One was that she loved his sister better than himself, an idea based on the fact that she had not left him until after the birth of the sister. He transferred this phantasy: his foster mother would not like him and keep him because she had a daughter of her own; the therapist would give his hour to a girl patient instead of continuing to see him, or she had a baby girl of her own whom she loved more than him. His treat-

ment interviews were full of his anger and resentment toward the mother who had left him. This anger was strongly felt in the relationship to the therapist. He wished to kill the therapist by starving her, by eating her up, by poisoning her, by torturing her with fire or cutting the skin and flesh off her bones, leaving only a skeleton. Other hostile phantasies were directed toward the husband or the girl baby for whom he thought his mother had deserted him, toward the therapist's husband and her child patients, toward his foster father and foster sister.

In spite of his phantasies that he was a grown-up man, he had not been able to establish masculine identifications, having been blocked in doing so both by his hostility toward men—so that identifications depended upon destroying and replacing them and occasioned too much guilt—and by his idea that girls were preferred to boys, so that masculine characteristics seemed to him a threat of danger of losing love from any mother person. It was only as he lived through all these anxieties and conflicts, in the relationship with the therapist, that he could gain courage to love the therapist and his foster mother without fear of suffering through another loss, and develop a feeling of affection and admiration for his foster father which permitted him to make masculine identifications on a positive basis.

His repressed emotions and phantasies were intimately associated with his wetting and soiling, and also with his reading disability and his misspellings and miswritings. In the course of the treatment, the phantasies unconsciously motivating the wetting and soiling were revealed: at times, the desire to be a baby again, loved and cared for by the mother, was associated with wetting and soiling himself; again there were phantasies of oral impregnation and anal or urethral birth connected with wetting and soiling, whereby he protected himself from recognizing sex differences when he believed that boys were not as well loved as girls; most often, the wetting and soiling represented hostile and sadistic wishes—urine was hot enough to burn any one to death, feces could be used to make poison gases or bombs to kill people, urine and feces mixed together would make a poisonous drink with which to kill people, and so on.

Just as his wetting and soiling had such unconscious phantasies underlying them, so the misspellings and miswritings represented unconscious phantasies and feelings that he had feared to express openly until able to do so in the treatment relationship. The peculiar marks that he had made were described by him as "Chinese writing"; they were associated with phantasies of killing by torture as did the Chinese or Indians. Certain marks, in his "Chinese writing," were picture-writing for the words tiger, alligator, and skeleton, certain lines being legs, others mouths, and dots being eyes. Tigers and alligators, he elaborated, could eat off skin and flesh, leaving nothing but a skeleton; this was what he wanted to do in anger and revenge. Reversals in writing represented his wish to write Hebrew instead of English; one of his explanations of his mother's desertion was that she was a "Goy" who had left him because he was Jewish; he had heard how badly Goyim treated Jews. Hating her for having been as bad to him as a "Goy," or perhaps having been a "Goy," he would not learn to write the "Goy's" language. He wanted to write Hebrew, but did not know how to make "Hebrew letters," so he could only try to write Hebrew with English letters and

words, by writing the latter backwards. His misspellings were what he called "speech writing," and once he had given this clue to an understanding of them, it could be seen that if the letters he combined were sounded phonetically, they approximated familiar words. Some of his words and sentences in this "speech writing" represented the phantasies previously described in connection with his wetting and soiling. But there was another motivation for the "speech writing"—he had been angry at having to attend speech class and tried to get revenge upon teachers who thought him "too dumb to talk" by puzzling them with his phonetic spellings of words and saying to himself, "Well, you're too dumb to read."

While his miswritings and misspellings thus carried unconscious and repressed feelings and phantasies in a form disguised from himself and others, and were an expression of aggressive feelings which he feared to recognize consciously, until he could do so in treatment, his failure in learning to read was more closely related to his difficulty in establishing masculine identification. From the beginning, he described husbands and fathers as big men who could *read*, work and earn money, and have babies. In his wish-fulfillment phantasies, he pictured himself as able to do all of these things; actually, he could not make a start toward acquiring even the first of these abilities because of his guilt over his hostility to men and his phantasies of destroying and replacing them. Another emotional factor in his not learning to read was his hostility to women, which motivated a refusal to do anything they wanted him to do. As he himself said, toward the end of his treatment, "You know I used to hate women, but now I love them." And again: "All those years before I came to clinic, I only hated people, and I wouldn't do a single thing for them. It isn't so hard to get promoted—all you have to do is do the work like your mother and teachers tell you. Now I love them, so I'll do what they say. But when I hated them, I wasn't going to work for them."

If the preceding case is of especial interest because of the accuracy with which the boy could describe how he felt when he was unable to read and spell and write correctly, two other treatment cases are of interest in suggesting how early in the child's life feelings may become associated with reading and writing.

Case 5.—A six-year-old boy was referred to the clinic because of difficulty with reading and first-grade work. In addition, he was a feeding problem, refusing to eat and remaining undernourished, though physicians could not find any physical basis for his refusals of food, and aside from his underweight he seemed in good health. In his twenty-two treatment interviews, the emotional background for both his feeding problem and his failure in school appeared.

In the first three interviews, he manifested extreme fear, becoming frightened lest his mother leave him, lest the bogeyman get him, and so forth. Panic occurred whenever he had expressed any feeling of hostility in play and conversation. By interpreting his feeling that he should be punished for what he had said or done, showing him that his fears

were imaginary and not really true, and joining in his aggressive and destructive play activities so that he did not have to bear the full burden of responsibility for them at first, the intensity of his fear was reduced by the end of the third interview so that he could express his feelings more freely, as he became secure in the relationship with the therapist.

In the fourth interview, he wished to play house, naming himself after his father, the therapist after his mother, and two small dolls after himself and his little sister, who was three years of age. He spilled the little sister's milk (water from a toy nursing bottle) and said that she would not have anything to eat. But immediately the doll representing himself became ill, could not eat, and had to be taken to a doctor. The therapist interpreted that he must have spilled the milk because he disliked his sister, then thought he deserved to get sick. He replied that his mother would punish him for spilling the milk, but when the therapist interpreted his fear that she also might be angry at him for doing so and stated that she was not angry, he filled the bottle again and deliberately emptied it so that the sister would not get her food.

In the next interview, his hostility to his sister was more open. He built a house from blocks, planning to destroy it with a cannon that shot marbles for bullets. When it was completed, he said it was the house where the baby lived, placed the doll which had represented his sister in the previous hour inside it, and said that she would be killed when he shot down the house. While shooting, he sang: "Now we'll kill the baby! Now we'll kill the baby!" with great delight. He repeated this play and song until the end of the interview, when he demanded that the therapist send away the next child and keep him longer. She interpreted his wish to be the only child with her, as he wished he could be the only child with his mother. When he next came, he resumed the play of shooting the baby sister. He remarked that she was not a baby now, she could walk, but when she had been a baby, his mother had always held her in her arms. The therapist interpreted his jealousy and his anger at the mother, as well as at the sister. In response, he enlarged the scope of his activities, shooting dolls representing both mother and sister, while he sang: "Oi, oi, oi, we'll kill the mamma, we'll kill the baby, we'll kill the mamma!" over and over again.

In the following hour, he told how his mother and father slept together, while he had to sleep by himself in a room with his sister. He asked if the therapist had a husband and informed her that if not, he would be her husband, and sleep with her, and they would have a baby of their own. He would love this new baby, he explained; it would be different from having a baby sister. Chancing to see a man passing in the street, he pretended to shoot him with a toy gun, said it was the therapist's husband whom he had killed, and renewed phantasies of how he would stay all night and sleep with her and they would have a baby. When these phantasies were interrupted by its being time for him to go home, he was angry, but left consoling himself that next week he would be a bigger boy and would be able to stay all night.

In the next two interviews, he enlarged upon his jealousy of his sister, describing how she could have a nursing bottle at night while his mother

would not bring him a drink, if he asked for one, but would merely tell him to sleep. All the things his mother once did for him, when he was a baby, she now did for this sister, he declared. He picked up a doll, hit it, and inquired what would happen if he hit a mother in the belly when she had a baby inside her; would it kill the baby? He turned to the therapist and reproached her, "All you should like is me." He said that when he was grown up, he would have fifty children, all boys; he hated girls. But then he confided that sometimes he wished he were a girl instead of a boy, if only his mother would love him as much as she did his sister.

During these twelve interviews, he had continued to do poorly in school, and at about this time, he was demoted to kindergarten; whereupon his mother removed him from school for the rest of the term. After this, some of his feelings about school work came into the treatment interviews. In the thirteenth, he for the first time used a printing set that was among the play materials. He talked of the letters he printed as if they were pictures of wild animals—a Q was a wild bird, an M a wild dog, and so forth. He added that wild animals were bad because they would bite people, and became afraid that the letters he had printed would bite him, begging the therapist to put away both printing set and the papers on which he had printed. She commented that there might also be wild boys who would feel like biting people, when angry with them. He replied that he did not wish to be wild and bad, but immediately continued: "Wild boy, wild me, I will bite you." He went on with a phantasy that the next patient was a girl, and reproached the therapist for seeing girls—"If you must see other children, you might at least have only boys."

In the next interview, he accused the therapist of having a little girl of her own, whom she loved more than him, and of seeing his little sister. The therapist explained that this was his own imagination, that he knew she did not see his sister, and she would tell him that she did not have a little girl. If he was imagining such things of her, she suggested, he might imagine his mother's loving his little sister best, too.[1] He said he would cry if he had to leave his mother and he thought his mother would cry, too, but he still thought she liked his sister best. He cut out pictures of wild animals, and said the crocodile could bite the mother bear. If he were a crocodile, he could bite his mother and eat her up. He had, in previous interviews, expressed fear that the bogeyman would eat him up, that if he ate turkeys or chickens they would come back to life and eat him up, and so on. These fears were now interpreted as his feeling that, because he had wished to eat up people, he would be eaten up as a punishment. Immediately he placed a small bear which he had cut out beside the big bear, whose mouth was open, saying, "The mother bear won't bite the little bear. She is only smiling at him."

In his fifteenth interview, he began to talk about sex differences. He said that he could stand up to urinate, while the therapist could not, because he had a "petsy" and she had not. He then wanted the therapist to examine him, to show her his "petsy" (penis). He felt guilty, then, and said his mother would whip him; she had told him it was

[1] Later interviews of the social worker with the mother indicated that the mother really did care more for the sister.

dirty to talk about his "petsy." The therapist interpreted his fear that she also would be angry, and his fear that his mother and the therapist might not like him because he was a boy, if he imagined they liked girls best. At once he turned to play at the sand box, mixing water with sand, and telling how he would like to throw sand and water on little girls, to cover them with urine and feces. He then mixed a cake which he said was poison and would make people sick. He would make the therapist eat some, and take some home for his mother; he hoped that they would both get sick and have to have enemas, as he used to have when he got sick, and that the enemas would hurt them. His anger at the therapist and his mother, when he feared they might like girls best, was interpreted.

The next two interviews were concerned chiefly with his wishes to eat up his father, as a magic means of getting his strength, getting his big penis, and growing up to be a man. He modeled a horse, an elephant, and a gorilla from clay; then pounded them to kill them. He made a man of the clay, killed him, and said he would cut off his head, pound him flat like a piece of steak, cook him, and eat him up. Momentarily he was afraid of burning himself, until the therapist interpreted his ambivalence and guilt and his wish to grow up. He then pretended to eat his father, and said that now they would play house; he would be the father and the therapist would be the mother. In the following hour, he modeled a frog and a snake from the clay. His snake was the biggest snake in the world, he announced; it was big enough to have babies, only it didn't know how to get them. But he went on to make two holes in the frog, saying that this was a girl frog; one hole was where she made "tentions" (feces), the other was where a "petsy" could go into her. He remodeled his snake into more of a penis shape, stuck it into the hole in the frog, and said: "The boy's petsy will fit into the girl. I wish I had the biggest petsy in the world, one bigger than my father's; then I'd be the champion of the world."

In the next interview, the nineteenth, he intimated that he was ready to stop his visits to the therapist. He had missed the previous date for an appointment, and explained that he had gone to a party instead of coming to clinic and had had a better time. He had not wished to return to the clinic, but his mother had insisted on it. He added, to the therapist, "But I still like you, so I guess I can come, even if I don't need a doctor any more." He explained that he had needed a doctor when he was small and so afraid, but now he was bigger and not afraid of things as he used to be. He continued that he could make a poison cake for the therapist again, but he could eat it without getting sick himself. He could cook a man and eat him up without burning himself. Sometimes he felt like being bad, he added, with a grin. The therapist commented that he used to get sick when he felt like being bad, instead of feeling that way. He jokingly remarked: "Maybe I could get sick; then I wouldn't have to come any more." The therapist inquired if getting sick had also been to get what he wanted—perhaps to get the mother to take care of him instead of his sister. He answered yes, but it was no good getting sick, for she took care of his sister all the same, and made him go to doctors. He had been to three different doctors, but here he had got well, he added. He went on to tell how he got bad marks at school, dramatizing how he had held his book upside down

and pretended not to know what was the right way to hold it; how he had made believe he did not know even the names of things in pictures, and so forth. The teacher had said that he was dumb, had sent him back to kindergarten, and then his mother had taken him out of school. The therapist wondered if he had pretended to be dumb to get even with his mother for sending him to school while his sister stayed with her, and so that his mother would let him stay at home, knowing that she would not send him to kindergarten. He agreed with these motives, but said that he would go back to school next term; he was big enough to go to first grade now.

Three more interviews were agreed upon, before the treatment was ended. In those interviews, he expressed ambivalent feelings about leaving the therapist, but also repeated many of the play activities which in earlier interviews had caused fear and guilt, with satisfaction in being able to engage in them comfortably.

This boy's refusal to learn reading is easily understood as a part of his whole conflict in relation to his mother; he disappointed and annoyed her by his failure in school, just as he felt disappointed and angry with her; also he gained the satisfaction of staying at home with her instead of having to leave her with his sister all day while he was in school. More unexpected, perhaps, was his projection of aggressive wishes onto letters, regarded as pictures, with the anxiety and guilt over his aggressive feelings projected as fear of the letters which he thus endowed with his emotions.

A similar projection of aggression onto letters was evident with another young child.

Case 6.—This five-and-a-half year old boy also had a baby sister three years younger than himself, of whom he was extremely jealous. His fears, which woke him up at night, took various forms—fear of being hurt or injured, of being sent to jail, and the like. Back of them were his death wishes toward the sister for robbing him of his mother's love, and toward his mother, for preferring the little sister, as he imagined. Only excerpts from the interviews in which the feelings and phantasies were associated with his reactions to letters will be given.

After he had, in a series of interviews (there were thirty-two altogether, in this case) expressed some of his feelings concerning his mother and sister, transferred to the therapist, he started to use the printing set. He printed the letters F and E, then the letters C, G, and U. He said that the first two letters were bad people holding guns, the last three were ready to bite—they had their mouths open. He was afraid that they would shoot him or bite him, and had to get them out of sight quickly. Aggressive phantasies followed in the next few interviews. He wished to be a giant, so that he could produce large amounts of urine and feces. Then he could fill a bathtub with urine and drown his little sister in it. Or he could make bullets from feces to put in guns and shoot and kill his mother and his little sister, the therapist,

and other children who came to see her. He could also make bombs from the feces, put them in beds, and while his mother and sister, or the therapist and other children, were sleeping, the bombs would explode, set the beds on fire, and burn them all up and kill them. Again, he would mix urine and feces to make a cake which would poison his mother or the therapist; he would keep some of the cake until it got old and had worms in it, when he would feed it to his sister and the worms would bite her inside and eat her up. (His mother had scolded and punished him for attempting to bite his sister.)

Later on, when he was in a more affectionate mood toward the therapist and his mother, associations of sex feelings and phantasies with letters appeared. He printed the letters O and D, always printing them two at a time, one on top of the other. He said that they were doing bad things and was afraid at first, but went on with phantasies of urinating into the mother, to give her babies, which he dramatized in play with a rubber cat and dog. He filled a rubber dog with water, squirted it out through the hole where the whistle was located into a similar hole in the rubber cat, and said that the little boy was urinating into the mother, that he liked to do it; he was filling her full of babies, but he ought not to do it, because only fathers were allowed to do that to mothers.

In one of his last interviews, when his feelings had been brought out more fully and his fears had relaxed, he again printed letters, was no longer afraid of them, but colored them and took them home with him to show his mother how pretty they were.

One more case may be briefly summarized, although the treatment was incomplete, because the emotional background for the disability for reading is different, in some details, from previous ones.

Case 7.—A nine-year-old boy had never learned to read in spite of attempts at remedial teaching at school. He was also quarrelsome with other boys and antagonistic to the teachers. Just before he entered school, his older brother had died. Jealousy and hostility toward this brother, who seemed to him to retain more of the mother's affection in death than he, the living son, possessed, were evident in his interviews.

At first he dwelt on his wishes to be good, to love people and never to hurt any one. But soon he began to accuse the therapist of preferring other boys who were her patients and to engage in play and phantasies dealing with destructive and sadistic impulses directed toward these other patients and the therapist. He told of how the teachers, in his view, treated other pupils better than him. Later, he admitted the real feeling (which he had transferred to the teachers and other boys at school, just as he had transferred it to the therapist and her other patients) that his mother cared more for his dead brother than for him. He described her weekly visits to the grave, how she wept over it, decorated it with flowers, and so forth. He told how his mother always was talking of the dead brother, how good he had been and how bright in school work. "But I think he was a sissy; he couldn't fight, even if he could read," said the living brother, in angry

criticism. He then went on with phantasies, previously repressed because of his guilt over them, telling how he would like to dig up his dead brother's coffin, which would contain his skeleton, and remove it to a grave so far away his mother would never be able to find it, or burn it up and completely destroy it. He hoped that then she would forget the dead brother and love him.

Unfortunately, the treatment was broken off by the mother, after only ten interviews, while it was still incomplete. One other significant statement had been made during the interviews, however. The boy had recalled and described one of his first attempts at reading. He related that one of the first books he had tried to read was full of stories about war and people being killed. He had cried whenever he looked at this book and at last had torn it up so that he would never have to think of it again.

With this boy, it would seem that reading early became associated in his mind with stories of death, which was a painful subject for him, with his guilt over his repressed hostility to his dead brother and his unconscious grave-robbing phantasies. The feeling that his mother preferred the dead brother, and his consequent resentment toward her and the brother, were transferred to the teachers and the other boys at school. He could accuse the teachers of preferring other boys to him, while repressing the more painful accusation against his mother, and he could take out his unconscious anger and hostility upon the teachers and other pupils with less guilt than if these feelings were recognized as directed toward members of his own family. To his mother's praise of the dead brother, he opposed the criticism that he had been a sissy; in his anger and disappointment, he was unconsciously impelled to be the opposite: he was no sissy; he could fight, if he could not read. Thus, a negative attitude toward learning to read became, in a sense, a part of the boy's problem of development and growth. Confronted with his mother's idealization of his dead brother, and her urge to have him like the dead boy, he had to resist this pressure strongly and to be different from the brother, in an effort to preserve his own individuality.

Results of Treatment.—In discussing the results of treatment from the point of view of follow-up reports upon the patient, we are limited to cases in which such reports are available. Of the cases used as illustrations, we have no information regarding Case 6 or Case 7. The boy in Case 3 showed two years' improvement on reading-achievement

tests at the end of his incomplete period of treatment, although attempts at remedial teaching had not helped him with reading. His proficiency in reading was still two years below his school grade, however, and the last report indicated that he would have to repeat the sixth grade. He was said to be less reticent and more outgoing in personality.

The boy in Case 4 completed his treatment in November, 1935. During the time of treatment, his school work improved steadily and he was twice promoted, though he had never been promoted before. Around the end of his treatment, there was a period in which he had some recurrent trouble with school work; he was not promoted in February, 1936. He had suggested that he would like to have tutoring, but his foster mother wished to help him rather than have the agency that acted as his guardian arrange for special teaching.

However, from an interview with the boy when he came back for a visit in April, 1936, it seemed that the renewed difficulty in school, as had been suspected during his last treatment interview, was a part of his reaction to the termination of the treatment and the separation from the therapist. It had been very evident during the treatment interviews that his pattern for handling the loss of his mother had been one of regression and repression. As he himself described it during treatment, as he relived the separation from the mother very vividly, when she left him, "he forgot all he had ever known," in his effort to forget her. In the visit last April, he said that "once he had been able to forget the world"; he had thought he could forget the therapist and "all he had learned with her," but this time he had not been able to forget; he had to remember her even if he did miss her so much.

Although there was the failure of promotion after the treatment was ended, his social relationships with other children continued to be satisfactory and there was no marked recurrence of the regression to wetting and soiling. Because of the length of treatment in his case, and the intensity of feeling that he had put into the relationship with the therapist, it does not seem strange that the separation from her required a period of readjustment, even though there had been

a fairly long termination period, the ending having been set in advance and the boy having shared in setting the time for it. It is only natural that he had some tendency to repeat the same pattern of repression and "forgetting" after the loss of the therapist that he had used once before in a situation involving the loss of a loved person. That he did not need to repeat the old patterns of complete withdrawal from social contacts and of regression, and that he could not succeed in the second effort at "forgetting," are better indications of his gain through the treatment than the question of school success alone. His need of a period for readjustment, as well as the partial effort to meet the new separation with old patterns, are not so different from what sometimes follows the ending of an adult analysis.

The boy in Case 5 completed his twenty-two treatment interviews in April, 1935. A report from the school states that he reëntered first grade in the fall of 1935, again did poor work and was to have been demoted to kindergarten or transferred to special class, but was again removed from school. While he had done well in his treatment, his mother had not utilized the case-work situation to admit any problem in her relationship with the child or any need for growth or change on her part. In this, she was unlike many other parents, who do utilize the case-work relationship for such purposes. There was a very real problem in her relationship with her children in that she actually did prefer the little sister to the boy, who, because he was the first child, had interrupted what she had felt to be a satisfactory marital situation. (Before his birth, the implication was of marriage as more like the continuation of a courtship period.) After the treatment, the boy had to return to a relationship with the mother that was practically unchanged. Some children are able to continue with the growth begun during treatment, in spite of returning to such unchanged family relationships. Apparently this child was not able to do so fully, to judge from the school report.

The cases selected for illustration were not chosen on the basis of treatment results, but because the material gave unusually clear pictures of how difficulties in emotional development were intimately associated with the failure in learning

to read. Other cases could have been selected in which the follow-up reports were more favorable, with respect to the later school progress, although the material was less interesting in relation to the trouble with reading. For example, a seven-year-old boy, whose case has been reported elsewhere,[1] has shown satisfactory progress in school and otherwise during the year since his treatment was completed. Again, we have follow-up reports on an eleven-year-old boy, who two years ago was about to be transferred from fifth grade to special class because of his reading disability, but who is now finishing seventh grade, after having had about six months of treatment (on the basis of one hour weekly).[2]

In any discussion of treatment results, it must be borne in mind that individual children differ widely with regard to capacity to enter into the treatment relationship and utilize it for emotional growth. Moreover, there are individual differences as to what continued use may be made of the treatment experience in the child's later development. Also, the reality situation for the child, in which he lives after the treatment is ended, may well be as important in determining what happens afterward as the child's responses to the treatment and his native capacity for development.

GENERAL DISCUSSION

Many investigators have noted the occurrence of personality and behavior problems in conjunction with reading disabilities and have advanced theories to explain this fact. Monroe, for instance, after careful study, concludes that while negativism or other unfavorable attitudes may interfere with learning to read, probably the emotional and personality problems develop more frequently as a result of the failure in reading.[3] Our material from treatment cases, which comes from a larger number than the samples chosen for illustrative

[1] "Psychogenic Factors in Some Cases of Reading Disability," previously cited.

[2] In this case, in addition to the emotional factors, there was a difficulty with eye-muscle movements. It is interesting, however, to note that improvement in reading began during treatment, before correction of this physical handicap by exercises prescribed by the doctor who examined the boy's eyes. It is assumed, in this paper, that physical difficulties should receive medical attention.

[3] *Children Who Cannot Learn to Read*, p. 105.

purposes in this paper, suggests very strongly that the reading disability often arises from the same sources of difficulty in emotional development, and in much the same manner, as the accompanying personality or behavior problems or neurotic symptoms, such as fears, illnesses without physical basis, infantile regressions, and the like.

Personality and behavior patterns ill adapted to reality situations and neurotic symptoms originate, in one sense, according to psychoanalytic theory, from an effort to solve ambivalent guilt conflicts. They afford a disguised expression of impulses and feelings that have had to be repressed and denied because of conflict, anxiety, and guilt. At the same time, they often relieve anxiety and guilt through self-punishment—as in the case of fears and illness symptoms—or through insuring disapproval or punishment from others for socially unacceptable behavior. Similarly, in many instances, the reading disability is a disguised expression of hidden motives, satisfying the need for punishment and relieving guilt by exposing the child to a situation of failure in school and to criticism.

While sex conflicts are evident in many reading disability cases, even more pronounced, in the material produced in treatment interviews, are difficulties in establishing masculine identifications and in handling aggressive impulses, together with excessive anxiety and guilt over destructive, hostile, and sadistic feelings.[1] In certain cases in which no overt behavior or neurotic symptoms are manifested, these difficulties of emotional development and integration of personality underlie socially conforming behavior, although the signs of emotional conflict appear chiefly in the educational disability and overactive phantasy life.

It has been mentioned that most of our reading-disability cases are boys, so that these conclusions are based on material furnished principally by patients of one sex. Monroe has attempted to explain why reading disabilities are more prevalent among boys. She suggests that perhaps reading defects, like certain biological variations, may be found more

[1] In this connection, see "Some Unconscious Factors in Reading," by James Strachey. *International Journal of Psycho-Analysis*, Vol. 11, pp. 322-31, July, 1930.

often among boys because the constitutional factors that impede learning to read are largely characteristic of the male sex.[1]

Perhaps a different suggestion may be made, tentatively, on the basis of our material. Possibly there are differences between boys and girls in the points at which they are most likely to meet with difficulties in emotional development. It has been stated, in psychoanalytic literature, that in early psychosexual development, "masculine" or active and aggressive strivings are usually held in check, in girls, by passive, feminine tendencies, so that the former seldom reach the same strength in girls as in boys.[2] Possibly, then, for boys development may be especially complicated on the side of handling aggressive and destructive impulses and feelings, in some instances, if these are stronger and less inhibited by counteracting forces at certain stages of development for boys than for girls. At least, in our treatment cases of boys with reading disabilities, the trouble with reading has seemed to be closely related to difficulties of this type in their emotional growth.

Aside from these differences in theoretical interpretations and explanations, we can at least state with some certainty that children burdened with conflicting feelings which they have been unable to integrate, and with an excessive amount of repressed hostility and aggressive impulses, are unable to enter into relationships with other people with real affection and positive feeling. This is clearly shown in treatment in the transference relationship to the therapist. It is equally characteristic, though less openly manifested, in the relationship to parents and teachers. We do things for people when we like them; children learn, at least at first, to please parents and teachers who are loved, in order to secure love and approval in return, as Anna Freud long since stated. If attitudes toward parents, which are transferred to teachers, are negative, rather than positive, interest in learning is decreased thereby, or refusal to learn results, in cases of extreme negative feelings. This resistance to learning may

[1] *Children Who Cannot Learn to Read*, p. 98.

[2] See: *Allgemeine Neurosenlehre auf Psychoanalytischer Grundlage*, by Herman Nunberg, Chapter III. Berne: Hans Huber, 1932.

well become associated with reading, because this subject is most stressed in the early grades by the curricula in most schools, and also because of such unconscious factors in reading as Strachey has described.

This also explains why, after treatment, such children learn to read without special methods of instruction, in spite of seeming disabilities previously. In the treatment, there is a discharge of repressed feelings, alleviation of anxiety and guilt, and achievement of better integration of the emotional life and of personality, in cases where the response to treatment is at all favorable. Also, the treatment permits the child to form relationships in which love and positive feelings predominate. There is then a double incentive to learning: the wish to please the loved persons and obtain their approval and the wish to be like those persons, to identify with them as ego-ideals because they are loved and admired.

It should be repeated that we do not advance these theories regarding the rôle of emotional factors as the sole explanation for reading disabilities, nor do we insist that treatment is the only method of approach which should be utilized. We believe that there are also cases in which emotional factors are less significant, in which other causes emphasized by previous investigators are probably the primary ones and remedial teaching may be preferable to treatment. But it is our opinion that emotional reactions and emotional difficulties may be too little taken into account and interpreted too superficially, in many cases, as resulting from the trouble with reading rather than as preceding and producing it. Our point of view would lead to a careful selection of the method of approach in each individual case of reading disability, with remedial teaching for some and treatment for others.[1]

It is very desirable that treatment of the child be supplemented by case-work with the parent. This is necessary to insure the continuation of the child's treatment, and also to afford an opportunity to the parent to work out those aspects of the parent-child relationship which are a source of anxiety

[1] In a recent paper, Tulchin reports cases of reading disability in which emotional problems were prominent, and describes a combination of psychiatric treatment and remedial teaching as being helpful. (See: "Emotional Factors in Reading Disabilities in School Children," by Simon H. Tulchin. *The Journal of Educational Psychology*, pp. 443-54, September, 1935.)

to the parent and which could not be modified by treatment of the child alone. If the parent has no opportunity to, or does not, utilize the case-work relationship for this purpose, it may mean that to some extent the treatment of the child is wasted effort, if an unchanged setting in his family relationships means new or repeated difficulties in his emotional growth.

Perhaps we should state that there has been no attempt, in this paper, to outline or describe the principles and techniques of treatment of children or case-work with parents, since the purpose has been to clarify the question of problems of emotional growth and development in relation to reading disabilities, and to indicate some of the ways in which such emotional problems may become associated with reactions to reading and learning to read.[1]

[1] For articles on the treatment of children and on case-work, see *Readings in Mental Hygiene*, especially Chapters I, VIII, and XIV.

THE FAMILY-CARE SYSTEM OF SCOTLAND*

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THE establishments for the care of mentally ill (lunatic) patients in Scotland on January 1, 1936, comprised 7 royal asylums,[1] 21 district asylums, 2 private asylums, 1 parochial asylum, 14 lunatic wards of poorhouses, and the criminal-lunatic department of the prison at Perth. The total patient population of these establishments at the beginning of the year 1936 was 18,353. Compared to state hospitals in America, the Scotch institutions would all be considered small. The largest asylum, the one located at Hartwood, had 1,486 patients; three others had respectively 1,249, 1,041, and 946 patients; the rest were all smaller.

Patients classed as "lunatics" cared for in private dwellings on January 1, 1936, numbered 1,257. The dwellings, although widely scattered throughout rural districts, villages, and cities, are relatively most numerous in rural communities.

Mental defectives in Scotland are cared for in certified institutions or in private dwellings. In 1936, there were 14 institutions specially provided for this class of patients. Together, they housed 2,833. The number under guardianship in private dwellings was 1,437. Some mental defectives are still cared for in asylums for the mentally ill, but no separate accounting of these is made in official reports.

The Annual Report of the General Board of Control of Scotland for the calendar year of 1934 calls attention to the

* EDITOR'S NOTE: This article is one of the chapters in a book by Dr. Pollock which is to be published in the fall by the Utica State Hospital Press under the title *Family Care of Mental Patients.*

[1] In the annual reports of the General Board of Control of Scotland, institutions for the care of mental patients (with three exceptions) are called asylums and the patients are classed as lunatics. This accounts for the apparently antiquated terminology used in some parts of this paper.

serious overcrowding of the asylums, and makes the following statement:

> "The only real hope of any relief to the congestion in the asylums to-day appears to be along the line of an acceleration of the boarding-out of suitable patients under private care, and the extent to which that is possible will partly determine the extent to which local authorities will require to face the provision of additional asylum accommodation. The system of boarding-out in Scotland has been attended with conspicuous success, and much credit for that is due to the interest and enthusiasm of the Inspectors of Poor or Public Assistance Officers upon whom have devolved the many and numerous duties of the selection of guardians and of associating the right patient with the right guardian. It is important that these officials should receive every encouragement in this part of their work, and that they should be supported therein by the public-health officials and the asylum superintendents."

The system of family care referred to so approvingly by the board dates back to 1857, but even before that time, mental patients were boarded out by officials of the poor.

In 1855, Dorothea L. Dix, who had already accomplished wonders in the improvement of asylums for the insane in the United States, visited Scotland as an ordinary tourist. While there, she became interested in the Scotch asylums and on visiting them found very unsatisfactory conditions. Her findings naturally gave rise to much comment. Learning that a movement was under way to discredit her work in London, she proceeded to that city, saw Lord Shaftsbury and the Duke of Argyle, and with their aid had a conference with the home secretary, Sir George Gray. The latter, after being informed concerning the situation, decided to appoint a royal commission to inquire into the "State of Lunatics and Lunatic Asylums in Scotland." A thorough inquiry followed. The report of this commission stated that there were in Scotland 2,839 patients in public institutions, including 8 asylums and 12 poorhouses with separate wards for the insane; 657 patients in 23 private establishments; and 1,363 in private houses. All types of care then in use were deemed unsatisfactory. The commissioners urged district boards to build new asylums and to license private homes, each home to care for not more than four patients. The following is an abstract from their report:

> "That all cases of insanity should be placed in an asylum is a proposition we cannot entertain; the welfare of the patients would not thereby

> be promoted, while the expense to the country would undoubtedly be greatly increased. . . . All great aggregations of permanently diseased units are evils which should, as much as possible, be avoided, as their tendency is undoubtedly to lower and degrade each constituent member of the mass. Viewed in a certain light, then, asylums may be regarded as necessary evils; . . . We would gladly see enacted, that any number of patients, not exceeding four, might be received into a private house. . . . Under some such provision we feel satisfied that a system of cottage accommodation would gradually spring up, which would not only furnish more fitting accommodation for chronic patients than the lunatic wards of poorhouses, but would also be calculated to prove a valuable adjunct to asylums. . . . The practical advantages of such a system would be the greater amount of liberty accorded to the patients; their more domestic treatment; and their more thoroughly recognized individuality."

In accordance with the recommendation of the commissioners, a supervised system of family care of mental patients was authorized by an Act Regulating the Care and Treatment of Lunatics which was passed August 25, 1857. From that time to 1913 there was an irregular increase in the number of "boarded out" cases, the number reached in 1913 being 2,908. During the years of the World War there was a decline, which has since continued at a slower rate. The reduction is partly accounted for by changes in classification. Some of the boarded-out cases formerly certified as "lunatics" are now certified as mental defectives. The number of the latter cared for in families increased from 555 in 1920 to 1,437 in 1936.

The Boarding-Out System.—Although all certified pauper patients in Scotland are under the supervision of the General Board of Control, asylum treatment is practically separate from family care. Many of the patients in family care never see an asylum, and the asylum superintendent does not know of their existence. A superintendent may recommend some of his patients for family care, but after they are placed in family homes, his authority over them ceases.

The administration of the boarding-out system was formerly vested in parish councils, of which there were 875. In 1929, a new Local-Government Act was passed. This act, on May 15, 1930, transferred to county councils and to town councils of large burghs the duties formerly exercised by district boards of control and by parish councils under the Lunacy and Mental Deficiency Acts. Accordingly, at present

county councils or town councils select the guardians and homes that are to receive patients.

Standards of care and administration, and rules pertaining thereto, are established by the General Board of Control, but the placing and oversight of patients devolve on the local officials. Moreover, the inspection by local officials is supplemented by visits by deputy commissioners representing the board.

A mentally ill patient may be placed in family care in any one of the following ways:

1. Directly by local authorities with the sanction of the General Board of Control. The patient must first be examined by two physicians and both must certify to his mental illness.

2. By transfer from an asylum to a private dwelling on the certificate of the superintendent together with the sanction of the board.

3. A patient discharged from an asylum whose name is still on the parish roll may be placed in family care by local authorities with the sanction of the board.

4. A patient on parole from an asylum for any period up to a year, if he has not recovered at the expiration of the period, may with the sanction of the board be placed in a family home.

The types of mentally ill patients placed in family care are described by Dr. George Gibson, who was deputy commissioner for many years, in the following words:

> "From a psychiatric standpoint, they may not present many interesting features. The types of mental derangement most to be met with are mild and chronic manias, patients with harmless delusions, dements, and patients showing the signs of congenital insanity from slight degrees of mental deficiency to idiocy. Suicidal and homicidal patients are naturally as entirely unsuitable for this method of disposal as are noisy, violent, restless, and wandering cases. Epileptic patients must also be regarded with a suspicious eye, and though patients suffering from epilepsy may be permitted to remain at home with their relatives, they cannot be regarded as suitable patients to be boarded out with strangers. It is not fair to guardians to send them patients with unpleasant habits, or those who, from physical infirmities, are unable to look after themselves."

As the success of family care depends fully as much on the guardians as on the patients, the former are chosen with great care. They must be substantial, intelligent house-

holders of good character and habits. Their family life must be wholesome, and all adult members must have a friendly attitude toward the patient when he is received in the home.

A guardian must have a dwelling large enough to furnish comfortable quarters for the number of patients assigned him. There must be adequate provision for heating, ventilation, and light, and the customary home comforts. In addition the guardian must provide suitable exercise, occupation, and diversion for the patients in his care. A guardian can care for but one patient unless specially licensed by the board to receive more. The maximum number permitted to a dwelling is four; the numbers most commonly found are one and two.

Many of the Scotch guardians have cared for patients for years; some even have grown up with patients in the home. These guardians understand how to manage their "boarders" in order to make them useful and happy. The example of these successful guardians is a potent influence in maintaining the Scotch system on a high plane.

Although nearly a third of the mental patients in private dwellings in Scotland are boarded with relatives, the advisability of the practice may be questioned. It may be taken for granted that the qualifications required of relatives for the position of guardian are lower than those required of others and that standards of care in the homes of relatives are not so high as in the homes of strangers.

Inspection of Family-Care Patients.—Although patients are cared for in separate homes without any attempt at grouping, an efficient system of inspection is maintained. Patients are visited every quarter by the district medical officer, and twice annually by the inspector of public assistance. In addition, a deputy commissioner of the Board of Control visits each mentally ill patient once a year, and each mentally defective patient twice a year. Local inspectors record their visits in a book kept for the purpose in the home of each guardian. The inspectors interview the patients and their guardians and make thorough inquiry into the household arrangements, the food served the patients, the work required of them, and other matters pertaining to the patients' comfort and welfare.

TABLE 1.—AVERAGE WEEKLY COST OF MAINTENANCE OF PAUPER LUNATICS IN THE DIFFERENT CLASSES OF ESTABLISHMENTS, AND IN PRIVATE DWELLINGS, IN EACH OF THE EIGHT YEARS, 1921–22 TO 1928–29

	1921–22		1922–23		1923–24		1927–25		1925–26		1926–27		1927–28		1928–29	
	s	d	s	d	s	d	s	d	s	d	s	d	s	d	s	d
In royal and district asylums, private asylums, parochial asylums, and schools for imbeciles..	26	4	22	4	19	11	20	2	19	11	19	10	19	9	19	10
In lunatic wards of poorhouses.....	21	8	17	10	16	4	16	11	16	8	17	3	16	11	16	3
In private dwellings	12	6	13	4	12	10	12	5	12	1	12	6	12	3	12	1
General averages.....	24	2	21	5	19	3	19	5	19	3	19	3	19	2	19	3

As the guardians know that they must maintain an adequate standard of care or lose their status as guardians, not many of them are found wanting. The inspectors naturally have many adjustments to make, but the difficulties found in family care are probably not relatively greater than those experienced in hospital management.

Cost of Family Care.—The rate paid guardians for the care and maintenance of mental patients varies considerably in different parts of the country. In general, family care costs much less than institution care. Table 1, taken from the annual report of the General Board of Control for 1929, gives comparative data of costs of the various types of care for eight consecutive years.

Data for later years are not given in the same way, but the 1934 and 1935 reports give comparative figures relating to costs, as follows:

TABLE 2.—WEEKLY PER CAPITA COST OF MAINTENANCE OF PAUPER LUNATICS

	1934		1935	
	Shillings	Pence	Shillings	Pence
In royal asylums	21	8	21	9
In district asylums	17	5	17	9
In lunatic wards of poorhouses	14	11	14	11
In private dwellings	13	3	15	1

In considering these figures, it should be remembered that housing or investment costs are not included in the amounts given as asylum costs. The weekly investment charge varies in the several types of institutions, but on the average is probably at least eight shillings. When this is added to the weekly asylum costs, it is found that they average nearly double the cost of family care. The saving effected by boarding out a patient is estimated at thirty-six pounds or about $180 a year.

Evaluation of the Scotch System of Family Care.—In estimating the value of the Scotch system, one must take into account the patients cared for, the guardians, and the general public. The testimony of deputy commissioners, medical inspectors, and non-official visitors is strongly in favor of the system.

A few direct quotations culled from annual reports clearly show the attitude of the welfare officials. Dr. Kate Fraser, an officer of the Board of Control, wrote in 1933:

> "I have much pleasure in testifying once more to the high standard of care bestowed upon the pauper lunatic and rate-aided mentally defective patients under guardianship in private dwellings. I should like to draw special attention to the attitude of guardians towards the whole welfare of the patients under their care. Very few, indeed, consider their duty to be accomplished when they have complied with the regulations by providing suitable accommodation, suitable occupation, suitable food, and adequate supervision. They go much further and by stimulation, by arousing interest, by arranging for recreation and occupation for leisure time, and by giving them a real home life, they add materially to their happiness and frequently develop latent capacities, hitherto undiscovered. This applies more especially to the certified defective, who responds readily to environmental influences and who, under such treatment, develops self-respect and comes to feel that, after all, he is of some use in the world and not a being apart as his previous treatment has so often led him to believe.
>
> "The success in boarding-out can be attributed to many factors—*e.g.*, the selection of patients, the care and supervision exercised by the local authorities, the care and interest of the medical officers, and the careful selection of guardians. All these factors are important, but the real success is due to the guardians. Were it not for their infinite patience, understanding, kindness, and care, 'boarding-out' would not have reached the high level at which it stands to-day.
>
> "The benefits of boarding-out, both of lunatic and defective patients, do not apply exclusively to the patients. I have noticed within recent years that the presence of such patients in the community is having a definitely educative effect. In areas where such patients are placed, people are ceasing to regard mental illness or mental defect as something to be shunned or feared. Greater sympathy and greater understanding is being shown by the general public, and a new and enlightened attitude is gradually being developed."

Dr. Aidan Thomson, Deputy Commissioner, writes in the 1933 report of the board:

> "I have been profoundly impressed by the value and the possibilities of the boarding-out system. I consider that it not only could, but should be developed further. It fosters a root principle of human life—namely, the life in the family, which is accepted as a normal, healthy unit. I do not think that any person would deny that he would willingly give up the electric light and other institutional conveniences with the abnormal life of the large group for a life with less material comfort in a small family unit. Surely a mode of life that runs along the normal course of national feeling must tend to greater mental betterment.
>
> "It is on this principle that the boarding-out system is working, and it is a sound and proper principle.

> "A basal factor in the public's attitude of doubt and questioning as to the benefit and value of boarding-out appears to be that the ordinary man does not realize that a person may be disordered in mind and even certifiable as insane, but that certifiability is not necessarily a reason for institutional care. This fact is emphasized when one sees some of the patients with their guardians. The patients are at times very disordered mentally; but one finds that the man or woman has been with the guardian five, ten, twenty years and is very much a member of the household."

Dr. Ferguson Watson, Deputy Commissioner, reports in 1931:

> "Generally, the care and supervision of boarded-out patients attains a remarkably high standard of proficiency. The great bulk of guardians have housed patients for many years. In numerous instances, their children have been reared in the same house, have taken their food at the same table, have regarded the patients as part of the household, and had become so devoted to them that when a parent died, a son or daughter took over the duties of guardian. Such instances are not rare, and there are in Scotland a great many guardians at the present moment who are grandchildren and even great grandchildren of the original guardian. Some of the most capable, the most devoted, and the most conscientious unrelated guardians are spinsters, whose chief object is neither profit-making nor a desire for the exploitation of cheap labor, but a genuine desire for companionship, and practical sympathy for those unable to guide their own lives.
>
> "It is seldom that any adverse remark is made in respect to old, established guardians. They welcome the official visit, they keep their patients clean, they dress them well, supply a dietary which is generally much superior to that which the patient had at home, vary the meals in such a way as to prevent monotony, and while they exercise tact and discrimination in supervision and discipline, they allow that amount of freedom which cannot possibly be allowed to patients in an institution."

Whether the Scotch system of family care could be advantageously adopted in America is a question worthy of consideration. Massachusetts, when it first undertook the boarding-out of mental patients in 1885, was guided to no small extent by the experience of Scotland. But family care in Massachusetts, although proving satisfactory for a limited number of patients, did not keep pace with hospital care and was not copied by other states. In the last few years, since Massachusetts has made family care an adjunct of hospital care and vested the placement of patients entirely in hospital authorities, a marked increase in its family-care system has taken place.

In this country, it seems certain that the state hospital

or institution under the general supervision of the state department must be the dominant factor in family care. The dominance of local authorities in Scotland is one of the weaknesses of its family-care system.

The Scotch system may also be criticized for failing to provide adequate psychiatric supervision of the mentally ill patients placed in families. When patients are placed by a hospital physician, he knows their condition and can determine the medical attention they should receive. Provision for such attention can be made in various ways. The patient may attend clinics, he may call on the physician at the hospital, or the hospital physician may visit him in his foster home. Nothing of the kind is provided in Scotland.

A further lack of the Scotch system is the supervision of family-care patients by social workers and occupational therapists. The dwellings in which patients are cared for in Scotland are so widely scattered that such supervision would be very expensive if not impossible.

Lastly, the Scotch system seems to forget the patients' need for social life. Some guardians, of course, provide a social outlet for their patients, but nothing in the way of community activities is planned for by the system.

Although it is evident that the Scotch method of placing patients in families is not entirely in accord with present standards, the Scotch system is worthy of careful study. It probably will be many years before hospital authorities in this country will have developed guardians with the skill and devotion manifested by the wise, kind-hearted, and ever faithful Scotsmen who are sharing their homes with their unfortunate fellowmen.

The fact of the continuance of family care in Scotland through more than eight decades is of itself strong evidence of its value as a supplement to institution treatment. The further fact that home care of mental defectives is notably increasing indicates that it is meeting public approval and proving advantageous to both guardians and patients.

MENTAL HYGIENE AND THE HINDU DOCTRINE OF RELAXATION

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THE importance of relaxation as a preventive and therapeutic measure in this age of hypertension, maladjustment, and neurosis is being very slowly, perhaps rather too slowly, recognized. And even when the value of relaxation is appreciated, its nature is not usually understood. Oftentimes it is confused with recreation, with change of climate, or with temporary discontinuance of an occupation. But it is well known that recreations do not always *recreate* individuals, nor does a trip or a holiday effect a radical cure of hypertensed persons. The nervous tension of the average man of to-day is not on the decrease, even though he avails himself of various types of amusement and recreation.

Relaxation is a definite psycho-physiological process. It involves learning and practicing. Relaxation is a much deeper and more individually centered problem than are recreation and taking a vacation, however necessary they may be.

Scientific investigators in the field of relaxation are few. Physicians, psychiatrists, and clergymen give, as a rule, only general advice about relaxation to the people under their care. Many of those who to-day practice relaxation, including the over-zealous followers of various cults, are not familiar with the physiological and psychological mechanisms and demands involved in the practice. Most of the time they do not know what they are doing. Exact information and guidance in the matter are needed.

This article does not seek to deal exhaustively with the subject of relaxation, but to draw attention to certain practical methods based upon the Hindu doctrine of quiescence, the fundamental principles of which are still practiced in India. There relaxation and quiescence have been closely associated.

The most dominant influence that led East Indians to emphasize this subject in the last four thousand years were the following: (1) a warm climate which generated a craving for rest, and a productive soil which facilitated the use of leisure; (2) early geographical isolation of the sensitive Aryan race between the majesty of highest mountains, on the one hand, and the luxuriance of tropical beauties on the other, contributing to the rise of a religion of contemplative abandon and a philosophy of the abstract unity of all things; (3) the weight of mystic tradition upheld by a long line of teachers and their submissive followers and sanctioned by Hindu and even Mohammedan kings.

These forces—physical, psychological, and situational—were most powerful in shaping the tastes and destiny of that nation. Their inevitable effect was in the direction of specialization in the mental "sciences," which in time took on a practical character. The supreme motivation came to be to put an end to the sources of suffering incident to human life. The radical remedy, according to the East Indian view, did not lie in changing or conquering the environment of life, but in educating the mind's reaction to it. There was also the attempt to close the door of the mind, through contemplation, on all disturbing or exciting stimuli. East Indians developed their own ways of attack, including intricate methods of self-discipline.

To-day in America many of these methods will be inapplicable, and the powerful motivations underlying them will be absent. That does not imply, however, that the practice of relaxation will not be sufficiently motivated. Quite the contrary, for the demand for relaxation is tied up with the nation's deepest urges for self-expression, utility, and meliorism. People here want to relax and will relax, not so much, perhaps, for the sake of satisfying a religious need as for the sake of health, mental and physical, and for greater and better accomplishments in life.

This separation of motives, if it is considered as a true separation, is, however, not traditionally Indian. The practice of relaxation did not constitute a separate branch of discipline in India, divorced from philosophical and religious practices. Nevertheless, some of the principles and tech-

niques evolved in India have independent psychological and hygienic value for all people; hence to-day it is possible to allow a separation of motive and, if necessary, certain changes in methodology.

The problem of relaxation, according to the East Indian scheme, is a problem of equilibration, conservation, and direction of neuro-muscular energy. It is believed—and the belief is interwoven with a thousand and one subtleties of logic and tradition—that physico-chemical energy in the so-called inanimate creation and life energy in the animate creation are different stages of the expression of one energy-continuum. This continuum, as individuated and expressed through our organism, attains at each moment of time, as a consequence of internal and external stimuli, different levels of normal equilibrium. This normal equilibrium is health. Ill health is an effort on the part of the organism to regain its normal equilibrium. This equilibrium is not static, but dynamic. The business of relaxation is an effort to help to maintain in a better way and at deeper functional levels this normal dynamic equilibrium, especially that of neuro-muscular energy, by relieving stresses and tensions in the system. And in this matter of relieving stresses and tensions and probably integrating the forces of the body through the practice of relaxation, the habit of "quiet attention," the Hindus say, is very important. Why this is so, is not sufficiently explained, except that, though mind and the energy-continuum are seemingly interactive, absolutely speaking, mind has the directioning influence. This is in line with the Hindu philosophic theory of idealistic monism. Whatever the merits of the theory, the practice, which will be described later, has achieved results.

Alongside the problem of the equilibration of neuro-muscular energy are the allied problems of its conservation and direction into different channels with the greatest economy. People of this age spend more energy than is necessary, more than their systems will healthfully permit—a spending that leads to their general depletion. It is claimed that the practice of relaxation, with the help of quiet attention and allied methods, will rightly equilibrate and conserve that energy and bring about proper directioning in life situations.

In practical life we are aware how our attitudes and mental "sets" disturb or calm our behavior, our physiological response. If our boy is unusually late in returning home from school, we can work ourselves into a frenzy of worry which will cause our heart to pound and our brain to whirl; or we can take a normal attitude of expectancy, turning over in our mind probable alternatives as to the cause of his delay. The difference will depend upon our mental "set" and our oft-used reaction pattern. If one lies quietly on a sofa for a while, without indulging in too much thinking, one feels much more rested than if one keeps one's mind constantly busy under the same circumstances. The habit of practicing quietness has evident physiological effects.

Let us now turn to some of the practical stages of relaxation in which "quiet attention" comes into use.

1. *The Attitude of Relaxation.*—No one who intends to practice relaxation can ignore the *attitude* of relaxation. This is the first step. The components of the attitude of relaxation vary with different persons and with the same person at different times. When one is first told to assume the attitude of relaxation, one may have the visual image of one's own or some one else's relaxed, reclining posture or placid, expressionless face. Another person, under the same circumstances, may think of soft, slow speech or quiet murmur. Still another may recall moments of unworried, carefree moods; and a fourth may think of limp arms, hands, and legs, or sleepy eyes. Whatever the mental association or picture of relaxation may be, the important thing is to react or attend to it quietly. After a while gently put these images out of your mind and hold on to the relaxed attitude itself and the physical sensation of relaxation that accompanies it. At first the help of visual or auditory images may be necessary to bring on an attitude of relaxation, but with practice this attitude will "take possession" of you at your slightest wish and you will need no images. The working principle of this practice is the conditioned response. By quietly watching a poised person, you become poised yourself. Later, even by quietly recalling his name or poised behavior, you again become poised.

With your eyes preferably closed, welcome this attitude of

relaxation, relish it, and feel yourself in tune with it. At first you may not meet with a great deal of success; various parts of your body may remain tensed; your mind may still feel knotted up like a ball of stiff, tangled thread. Your quiet attention is not to be directed to those experiences, but only to the experience of the relaxed, or, rather, *relaxing attitude.* It is the attitude of relaxation or, rather, the quiet attention to the act of relaxation that counts at this stage. You are not to consider how much tension you have left. That will come for observation at later stages.

Or you may begin by actually listening to a piece of quiet, appealing music, looking at a beautiful painting, reading several stanzas of inspirational verses, or the like. You will feel rested. But that is not enough. Go beyond. The stimulus of music, paintings, poems, is only to induce in you the attitude of quiet appreciation and the accompanying relaxed mood. You need not at this stage keep wandering with the troupe of ideas that these stimuli will call forth. Observe during this stage the distinction between stimulus (object or idea), which may initiate relaxation, and the attitude of relaxation.

This attitude of relaxation is one of the most important initial methods and it can be practiced by children and adults every day for at least two or three periods of fifteen minutes each. A reclining chair, a couch or bed, or a convenient seat may be used. Of course the true success of this method will depend upon that of the methods to follow, with which it is linked.

With progress in the practice of this phase, it will be noticed that relaxation can be combined with action, and that they are not as fundamentally opposed to each other as they seem, for action can be performed with relative relaxation or equilibrium. If you have a conscious attitude of relaxation when you write, think, talk, walk, or during any other activities, those activities are almost sure to be better performed and you will undoubtedly be less exhausted. Let none suppose that quick actions or movements cannot accompany an attitude of relaxation. True poise in the midst of pronounced activity, observable in some persons, is a variant of relaxation. With practice, an automatization takes place;

you become conscious of the end product—*i.e.*, relaxed activity—but will not notice any attempt on your part to hold that attitude.

This attitudinal phase is the backbone of the other phases of relaxation, and it is an important item of mental hygiene, constituting the first point of attack on, and possibly a preventive of, hypertension in home and school. Can children who are naturally restless practice it? Yes, they can, if their parents and teachers set the example. Here as everywhere example is found to be better than precept. Restlessness in children should be welcomed as an evidence of their natural abundance of energy, and should not be dammed up, but it may be alternated with quiet. Relaxation twice a day, at home or in school, will establish in the child a habit pattern that will tend to exert a modifying influence on his behavior, and his restlessness will cease to be mere restlessness. It will find itself in a subjective setting or atmosphere of quiet and poise, gathering strength with the passage of time, and will eventually become a less disturbing factor in his personality. This has been tested in two children's schools. In the treatment of speech defectives and so-called nervous persons, this first method, combined with the method that follows, offers a very important approach. Clinical work along this line is being conducted in several places. The writer notices its splendid efficacy as a basic technique in the treatment of stuttering.

2. *The Relaxation of Muscles.*—This step may go with or immediately follow the first step, without which the voluntary relaxation of muscles is impossible. The first step is general, the second specific. Without the relaxation of specific muscle groups, the general attitude of relaxation on the part of the beginner will not take him very far. In the second step, you are to lie or sit comfortably and, taking various muscle groups of the body, relax them one after another; the muscles of the forehead, eyes, cheeks, jaws (upper and lower), lips, tongue, inside muscles of the mouth and the throat, outside muscles of the throat, right and left shoulders, back, right hand, right lower and upper arms, left hand, left lower and upper arms, chest and abdominal muscles, right and left buttocks, right thigh, left thigh, right calf, left calf,

right foot, and left foot. Or you can begin relaxing at the foot and go up by stages to the muscles of the forehead.

There are two slightly different methods of relaxing these muscle groups. The first is Jacobson's [1] and he has used it with much effect in his laboratory at the University of Chicago. Tense (he calls tensing "doing") each of these muscles, feel the muscle-sense of tension, then relax it (which he calls "not doing") more and more, taking upper, middle, and lower part of the body for successive periods of practice of one hour each. After several practice periods, the preliminary tensing of each muscle group may be abandoned and only the relaxation of it continued. After some practice, the subject may fall asleep toward the end of the period. This, Jacobson says, is one of the definite indications that the subject is relaxed or relaxing. Another definite indication is that the muscle fibers of the subject, for lack of difference in electrical potential, do not show any oscillation even to the extent of a millionth of a volt on the string galvanometer amplifying apparatus to which he is connected by needle electrodes for the purpose of the test.

The second method of relaxing the muscles consists in using the previously mentioned method of "quiet attention," and it has two approaches, direct and indirect. In the direct approach, you do not tense the muscles, nor are you asked to be aware of the residual or actual feeling of tension in them. With closed eyes, quietly "attend" to a muscle group, directing your mind toward it; you may visualize it, but that is not necessary. Only *perceive the muscle as it is,* however ill-defined the perception may be; then relax it—let it go. The letting go should be done with quiet attention. Abandon yourself to the relaxing act. You may not be able to keep this feeling of abandon more than a fraction of a second. Then again with quiet attention repeat the same thing. You may introspectively feel that you are gradually getting down to the second or third level of relaxation. It will take a few periods of practice to do it rightly without tension. The muscle groups, from forehead to foot and back up to forehead, are to be covered in this way. Any preliminary tension

[1] See *Progressive Relaxation,* by Edmund Jacobson. Chicago: The University of Chicago Press, 1929.

around the eyes, during this direct approach, will disappear with practice.

In the indirect approach you do not attend to nor attempt to relax any muscle. Continuing the general relaxed state that has come "over" you during the direct approach, you now repeat mentally the word "quiet," "peace," or any other soothing word, or feel the sensation of incoming and outgoing breath, including that of the rising and falling of the chest muscles, or tie your quiet attention to any other simple rhythmical perception or ideation. Continue this for a few minutes; then quietly slip into a state of "attenuated awareness" or attention which has no sensory or imaginal specificities; an awareness in which you are just conscious and yet not conscious of any particular sensation of the body, nor have you then any mental image or idea, nor are you seeking to welcome any. This is an almost sensationless and imageless state of quietness. To attain it is not as difficult as it sounds. This state may not last more than a few minutes or even seconds. If it does not, do not make any "fuss" about it mentally. You may be in and out of this for some time at each sitting, but be sure not to desire too hard nor to exert any great effort to be in it. If ideas or sensations appear, gently put them out of your mind; do not be disturbed if you fall short of consistent success. There will be times when you will feel the oncoming of sleep or when you will actually fall asleep. As you come to, open your eyes, move slightly, and begin again, but try to remain awake. Devote at least twenty minutes to the entire method. This "attenuated awareness" is of course distinct from "quiet focused attention" about which we shall have something to say presently. This form of awareness and relaxation is remarkably restful and recuperative, and shows its overflow effect in the form of poise when one is active and busy.

According to the East Indian doctrine, true relaxation is not equivalent to sleep because during sleep the equilibrium of the body is different from what it is during relaxation;[1]

[1] The difference between waking hours and sleep from the standpoint of electrical brain rhythm of intact human beings has been pointed out by A. L. Loomis (*Science*, Vol. 81, pp. 597–98, June 14, 1935, and Vol. 82, pp. 198–200, August 30, 1935) and by H. Davis, F. A. Gibbs, and W. G. Lennox (*Archives of Neurology and Psychiatry*, Vol. 34, pp. 1133–48, December, 1935). At the

hence relaxation should not be confused with sleep nor allowed to resolve into sleep during the practice, however much sleep is otherwise necessary and useful. True relaxation is marked by the passivity of sleep without the submergence of awareness characteristic of the latter.

From what has been said, a certain theoretical and practical distinction between Jacobson's method and the Hindu method of relaxation will be clear. Jacobson seems to minimize the importance of the attention factor or the factor of mental set as such in the practice of the relaxation of muscles. He even says it is tension-producing. And yet he utilizes and takes for granted first its voluntary, then its automatized form. Or it may be said that up to a certain point he traces the course of this factor and then suddenly drops it, letting the physiology of the body do the work of relaxation and calling it voluntary relaxation. The Hindu method uses the coöperation first of quiet minimal attention during the direct approach to the relaxation of muscles, and then of attenuated awareness throughout the rest of the process, when all direct attempts at relaxing muscles are abandoned. Secondly, Jacobson's relaxation permits sleep as one of its end products. In the other case, sleep is specifically kept distinct; only the passivity of sleep with a minimal awareness is permitted. Which method produces the deeper and more recuperative form of relaxation, or whether a modified method needs to be developed for ordinary persons as distinguished from advanced clinical cases, are points that can be decided only by further investigation.

Even if one does not wholly accept the thesis of Jacobson that the relaxation of the nervous system and consequently of the mind is possible only by way of the relaxation of muscles—provided sufficient medical attention has been paid to obvious structural or organic disturbances, if any—no one can deny the effect of the diminution of tone and contraction of the skeletal muscles upon the whole of the nervous system and viscera. And the reduction of proprioceptive impulses

psychological laboratory of the State University of Iowa the present writer is investigating the effect of prolonged relaxation upon the brain rhythm under different conditions. For the effect of response on brain rhythm, see an article by L. E. Travis, P. E. Griffith, and J. Knott in the *Journal of General Psychology*. (In press.)

from muscles for the purpose of general relaxation, and as part of special therapeutic measures, is also to be admitted as vitally important. Jacobson has demonstrated that conclusively in his clinical work. Nevertheless, one should not forget that during hours and hours of relaxation treatment Jacobson's patients had a definite mental set and used some sort of attention to the act of relaxing muscle groups, and that this must have had a profound influence upon them. But the efficacy of this phase and its methodological significance have not been sufficiently elaborated upon by him. It is this phase, this psychological factor, that has been more emphasized in and tied up with the Hindu system. Simply lying in bed and keeping the muscles still, without the intention and act of relaxation, is not enough to cure nervous and other diseases. It is not known what the exact mechanism is by which intention and attention affect liminal and subliminal neuro-muscular states as well as general metabolism for better health. Hence if some critic disagrees entirely with the above point of view and contends that it is not so much the intention to relax as the physical quietness and lying still that have the recuperative effect, at present we can only point to clinical cases as a practical counter-argument, waiting for further neurological evidence to support our belief.

If it be maintained that tension always accompanies attention and hence will foil the purpose of relaxation, the Hindus answer that the purpose of relaxation is not to relieve all tensions in the organism, but to eliminate such tensions as are not actually or potentially consonant with health. The incident tension present in quiet attention is not damaging to the state of relaxation. The benefit of quiet attention comes from a certain equilibrium which it helps to create in the body by reducing and yet almost perfectly matching the acceleratory with the inhibitory forces in operation in the system. Thus is the integration of interacting forces brought about.

Whatever the theoretical interpretation, we have found from general observation of the subject's appearance and behavior that this method produces definite relaxation. In

a series of well-controlled experiments [1] with a few subjects who followed the Hindu technique for some time, we obtained interesting results. The biceps and triceps muscles of the subjects were connected by needle electrodes to a resistance coupled amplifying system and Westinghouse oscillograph. We found a noticeable difference in action-current latency as between normal forearm movement against gravity and forearm movement immediately after relaxation. The normal latency/speed ratio was between .54 and 1.86, and the relaxation latency/speed ratio was between 1.10 and 4.41. The latter ratio is double, almost treble the former ratio. This shows that relaxation of this sort does bring about a difference in the electrical condition of the muscles.

In another series of experiments on passive movements, when the subject's forearm, instead of being moved by himself, was moved by the experimenter, we found adventitious electrical potentials from his biceps and triceps that were not of a proprioceptive origin, but due to unintended voluntary movement or righting reflexes. We found that relaxation was one way to reduce or eliminate these electrical discharges. All through our study we observed the efficacy, not simply of our specific method of relaxation, but also of the habit of general relaxation.

Furthermore, in some subjects we found that quiet, relaxed attention to an imaged movement of the forearm produced neuro-muscular results different from those produced by strained attention to the same mental act. Ordinarily, in the latter case motor units involved gave electrical discharges with a frequency between 14 and 20 per second, whereas in the former case there was either no determinable electrical discharge or discharges of a lesser frequency.

3. Relaxation through Ideation.—As a matter of daily practice or when you are tensed or overworked, sit or lie down in a comfortable place and read a book quietly, or with closed eyes go over a mildly interesting experience in a passive way. Think leisurely on what you read or on an inspiring picture, image for a few minutes a beautiful natural

[1] See "An Electromyographic Study with Respect to Speed of Movement and Latency, Disparate and Reciprocal Innervation, Passive Movement, Attention, and Relaxation," by B. K. Bagchi. *Psychological Monograph* (containing University of Iowa Studies in Psychology) Vol. 19. (In press.)

scene, or ponder on a lofty abstract theme, on a sublime life, on a beautiful poem, a rippling brook, the gentle rustle of the woods, the echo of lonely wilds, the high mountain peaks, endless desert stretches, rolling green landscapes, and the like. Think *quietly* on what interests you. Be sure that your thinking is more or less relevant. If thinking pertains to the domain of facts, it is plain thinking, revery, or cogitation, and if to the domain of values, it is called meditation. Here one "rides on the waves of many ideas," in many directions, though within a certain area. This step involves a certain amount of muscular relaxation through quiet attention to ideational matters. It is multi-directional attention within a unitary field. The habit of quiet introspection and thinking should be encouraged to a moderate extent in children as part of their mental hygiene, and also in adults, taking care, of course, that it is not overdone. Persons with too much of an introvertive leaning should abstain from it entirely.

In addition to the benefits of lying down or sitting quietly in the practice of this step, it has special benefits of its own, but the channels through which they come are somewhat different from those involved in the first two steps discussed. Here ideation and imaging, mixed as they are with feeling-tones and interest, may be considered as slightly diverting the neuro-muscular energy from the habitual and oft-used pathways and also sending ripples over the autonomic nervous system, probably mildly stimulating the ductless glands. The cumulative effect of all this is a general feeling of well-being, which is subjectively taken for relaxation and recuperation. Truly, nothing definite is known as to what the neuro-muscular occurrences are in abstract and concrete ideation, or ideation with definite feeling-tones, except for some tensions and changeable action current patterns in external muscles of the eye and the eyelid, the tongue and throat muscles, the hand muscles (especially in the case of the deaf mutes who use sign language), and other muscles connected with the thinking pattern, or probably changes in blood pressure, pulse rate, and so forth. We know that feeling-toned ideas decrease the electrical resistance of the skin by stimulating the sweat glands through the autonomic nervous system, giv-

ing what is known as electro-dermal response on a galvanometer. But again this decrease in skin resistance is not typical of feeling-toned ideas; it may be caused by other situations—for instance, movement. Then again it is not clear why in practical life the emergence of pleasant feeling-tones of a mild character, when one is tired or exhausted, is accompanied by a restful feeling.

Be that as it may, experiments show that too much ideation has not the highest relaxation value. A priori, it would also seem that the more ideas there are, the more neuro-muscular changes there will be, and hence we cannot expect in such cases the deepest level of relaxation.

4. Relaxation through Uni-directional Attention.—This step is to be taken when a certain amount of mastery over the first two steps has been achieved. That mastery may take a few days, weeks, months, or even a few years, depending upon the individual. As before, sit or lie down comfortably, seeing to it that no part of the body is tensed; be relaxed mentally—*i.e.*, free your mind of worries or too many wish fancies. This time, with closed eyes, do *not* entertain many images, however pertinent to one relevant subject matter, but focus your attention quietly, without straining yourself, for a short time on *one thought,* or one thought-image, or any one component of it. Take the auditory image of a tone, the visual image of a light or part of a light, of a picture, the memory image (visual or organic) of a previous experience of quietness, peacefulness, or approaching sleep; a visual-verbal image of a word like joy, dawn, or any other short word or syllable; the "image-halo" of an abstract concept like love, friendliness, tolerance, starting with the memory images of specific illustrative instances, but later dropping them and holding on to the general "feeling"; or even the perception of the rhythm of breathing. The image may be visual, auditory, verbal, or visual-verbal, but preferably not motor. However, not the image, but your quiet attention to it or to its quiet, imageless after-effect is the important thing. Nor are you to consider a mosaic of the details of the image; any tiny aspect of the experience will do. You should not exert your attention to make the image vivid, because vividness is not the important thing either. What is important is

your almost effortless attention first to the image, then to the practically imageless after-effect. It is needless to repeat that this attention should be quiet, not intense—just a steady flow of your mind, as it were. It is like the flame of a candle undisturbed by wind, like the steady stream of oil pouring down from a higher into a lower jar. When you practice this method, do not build mental castles, or try to "see" or "hear" things. Nor should you try to "suggest" anything to yourself. Such efforts are positively distracting.

At first you may notice a slight tension around your eyes or limbs. Relax them as much as you can. You may also feel the fluctuation of your attention occurring within a second or more. You should keep your mind corralled around the specific object-image or its quiet after-effect as much as possible in spite of the wavering of the mind. It is better not to practice this more than five or six minutes at each sitting twice a day until you experience some ease and mastery, because a slight tension may result if you do. That is, of course, an evidence of the "left-over" from old tense habits. You can practically push your eyes clear out of their sockets in "glaring" on an outside object, or you can focus them normally on it. Similarly, mental focusing can be done with a great deal of effort or strain or practically without any.

The difference between this last and the latter part of the second step is that in the latter "attenuated awareness" is cultivated with the help of quiet attention, and in the former quiet attention is cultivated on its own account. The second method is advised earlier than this one, not necessarily because it is easier, but because the novice in the practice of relaxation is more apt to be relaxed by slipping into the passivity of attenuated awareness as it approaches the borderland of sleep than he would be if he began to focus his attention right from the start upon something definite. In reality, success in one is bound up with that in the other, inasmuch as the deepest form of attenuated awareness comes with the practice of uni-directional quiet attention. It may take a little longer for the beginner to get the recuperative value of uni-directional quiet attention, but when it is rightly practiced and becomes habitual, it is one of the handiest and most effective methods of relaxation and self-development. Quiet,

focused attention can be used in every situation in life with benefit. Useless thoughts, movements, tensions, can be dispensed with and the right of way offered to the problem in hand. Emotional upsets can be forestalled or their effects mitigated, not only by general relaxation, but by quiet attention to some definite task.

In India this uni-directional attention is combined with almost infinite kinds of intricate practices. It is not our concern here to discuss them. Sometimes it has been combined with various types of breathing[1] for producing greater oxygenation of the system, even apnœa. Sometimes various parts of the body and special ganglia in the nervous system have been selected as the object of attention. The Indian claim is that through the operating medium of pran (life energy) quiet attention can create astounding effects in the body. Unfortunately, much of this subject has fallen into the hands of charlatans or vulgarizers. For interesting cases of remarkable control over the body, tested by physicians, see an article by Richard Garbe in *Monist,* July, 1900. The time has now come to check scientifically the major results that are supposed to follow from such practice and to determine whether or not there will be any general use for some aspects of it in the everyday life of the average man.

In India and in this country, those who have seriously practiced relaxation are aware of what it can do. Persons are known who, through ten minutes of relaxation, can experience a freshness like that which follows an hour or more of good sleep. Relaxation is not simply throwing oneself on the couch and courting passivity in a haphazard way. It is something to be systematically learned. Aside from the benefits that normal children and adults can derive from it, its clinical value is now being demonstrated. It was reported some time ago at a meeting of the American Association for the Advancement of Science that a large number of sufferers from stomach ulcers have been cured through relaxation. Mild psychoneurotic cases can be helped by simpler forms of relaxation if the coöperation of the patients can first be se-

[1] See "Oxygen Consumption During Yogic Breathing Exercises," by Walter R. Miles and K. T. Behanan. Paper presented at the scientific session of the National Academy of Sciences, April, 1935.

cured, and some of the symptoms of the organic cases may be allayed by it.

Relaxation can always supplement psychiatric, psychoanalytic, and medical methods. It can moderate the symptoms of phylogenetic nervous instability in many mild cases so as to prevent permanent maladjustment. Relaxation goes very well with good common-sense advice or a sound philosophy of life, for it creates a psycho-physiological condition of quiet which makes it easier for such advice and such philosophy to strike a nervous root, to use a figurative expression. Relaxation should never replace action, but alternate with it. This rhythm is paramount to our growth and adjustment. Those East Indians who are too much relaxed have not observed this rhythm and hence have suffered mentally, physically, and in many other ways. The ideal of the most universally revered Indian book, *Gita*, is action plus meditation. This ideal has always been followed by the best representatives of that country.

The part that racial differences play in the practice of relaxation cannot be satisfactorily answered as the study of such differences is a new one, and scientific evidence is lacking as to the relationship between racial characteristics and ease and success, or otherwise, in the practice of relaxation. As pointed out before, the climate of India and the traditional background may have created a psychological predisposition for it in the people. Nevertheless, it is not unthinkable that, given suitable opportunities and proper social stimuli, a similar predisposition may gradually be created in the people of this and other countries. As for physiological predisposition, we do not need a warm climate to prompt or enable tensed people to relax. The fundamental physiological mechanism of most races is practically the same; whatever variations there may be (*e.g.*, slow metabolism of races in the tropics who practice vegetarianism) would not make a great deal of difference so far as the ordinary practice of relaxation is concerned. If members of all races can go to sleep, they can all relax as well, and relaxation, as has been said before, can be termed *rest* or the passivity of *sleep plus a certain kind of awareness.* The active nature of the people here may, at the beginning, set up a psychological resistance

toward the practice of relaxation because they are not accustomed to meeting its demands. But that would be merely a passing phase in the situation. What is needed is scientific investigation and an organized social stimulus in this regard. With these present, the proper response will follow. Busy people of this country need not fear the onset of national laziness as a result; the climate and their social and national inheritance will take care of that. What will occur will be a toning down of their hypertensions, a relief from the evils that arise from it, and a stimulation of balanced activity.

EPILEPSY IN THE STATE OF MICHIGAN

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RECURRENT fits and attacks of unconsciousness have for centuries been regarded as a disease entity and variously called "the sacred disease" or epilepsy. According to its derivation from the Greek, the word "epilepsy" literally means "a seizure." Being merely descriptive of a clinical syndrome, the term is not wholly satisfactory, but it is still applied to recurrent fits and periods of unconsciousness, for no other more clearly descriptive word has been found.

Epilepsy has been recognized for at least twenty-five centuries. Hippocrates, born 460 B.C., made observations and descriptions of it that might take their place in the textbooks of to-day. And descriptions of epilepsy are found in the earliest historical records of disease, so that it is possible that even such ancient writings as those of Hippocrates are merely repetition of facts that were known to physicians in 3000 B.C.

As scientific knowledge has increased, the conception of the cause of epilepsy has undergone marked changes. During the early stages of civilization, the condition was attributed to the temporary loss of the soul from the body. In some regions it was attributed to the possession of the body by some demon or other malignant spirit. In primitive countries such beliefs still exist among the natives, who employ magic and religious rites to drive out the unwanted spirit. The concept of epilepsy as a contagious disease, which was common during the Middle Ages, is thought to have sprung from this ancient belief that the disorder was due to seizure by demons. Patients were strictly isolated and as late as the middle of the fifteenth century isolation hospitals for victims of epilepsy were still in existence.

The first statement that epilepsy is not a "sacred disease," but rather a disorder due to natural causes was made by Hippocrates. His contention was that the only reason for ascribing the condition to the gods was the fact that the nature of the disease was incomprehensible. He believed that seizures were connected with humidity of the brain. In the centuries that followed, various descriptions of epilepsy were added to the records, but there was little advance in the understanding of the disease until the advent of modern scientific methods of study.

Modern scientific research on the problem of epilepsy began during the nineteenth century. Experimentation comparable to that of to-day was applied to the problem of epilepsy by Brown-Sequard, who published a report on the experimental production of this disorder in 1869 and 1870. At about the same time Hughlings Jackson, a young physician in London, was making important clinical observations. These finally led to the recognition of a special type of epilepsy which has come to be known as Jacksonian. There is no single complete and satisfactory description of this by Hughlings Jackson himself, but his various clinical reports and discussions contain all the data necessary for a full description of the disorder. With the advance of science since the time of these two investigators have come many suggestions relating to the etiology and therapeutics of epilepsy. Heredity, alcoholism, infection, lesions in the central nervous system, dysfunction of the endocrine glands, digestive disorders, mechanical pressure, and many other factors have been held responsible for epileptic attacks, although no adequate indication of the fundamental etiological rôle of any single or multiple factor has been demonstrated.

The literature relating to epilepsy reveals that, despite the importance of the disorder, the extent of research resulting in conclusive findings is so meager as to suggest that the study of it has scarcely begun.

The syndrome commonly called epilepsy is a chronic disorder characterized by fits or attacks in which there is loss of consciousness, with a succession of tonic or clonic convulsions.

The "grand mal" attacks are typical convulsive seizures, having the following characteristics:

1. Prodromata, generally of a sensory character. At times there is a vasomotor or psychic disturbance.

2. Initial cry, shrill and startling.

3. Very sudden loss of consciousness.

4. Pupils dilated, do not react to light. The eyes remain open at the beginning of the seizure.

5. Tonic, then clonic spasm of muscles (unilateral, partial, general).

6. Spasm of respiratory muscles which may lead to asphyxia.

7. Spasm of the muscles of the jaw (biting of the tongue, bloody foam).

8. Relaxation of spasm with movements becoming clonic and then intermittent.

9. Prolonged stupor or profound sleep; gradual recovery of consciousness.

The active convulsive seizure lasts but a few minutes. The deep reflexes may be diminished or increased.

Some of these symptoms may be absent in typical attacks. The most constant symptoms are the loss of consciousness, the dilatation of the pupils, the spasm of the muscles, and the stupor or sleep after the convulsive movements have ceased. The diagnosis cannot safely be made unless at least two of these symptoms are definitely present.

The typical minor attacks (petit mal) are characterized by a very transitory loss of consciousness without any muscular twitchings and without any other symptom. Unfortunately, these minor spells lead, often enough, to major epileptic attacks.

Because of its somewhat dramatic nature, epilepsy is regarded by the general lay public with many fanciful misconceptions and misinterpretations based upon sheer empirical observation of isolated cases. And this tendency to draw unwarranted conclusions in regard to epilepsy and epileptics is not confined to the lay public, for various writers, even in the field of science, without adequate data and sufficient evidence, have drawn conclusions that detailed study has proved entirely foreign to the facts. The paucity of available data relating to the various factors and phases of epilepsy can be attributed largely, on the one hand, to the difficulty of obtain-

ing adequate knowledge and data both quantitatively and qualitatively and, on the other hand, to the failure of the public to appreciate the significance of the position of the epileptic in society, both from the standpoint of the social welfare and the well-being of the epileptic himself.

The position of the epileptic in society is a most unfortunate one. Between seizures he may apparently be perfectly normal in all respects, but the attitude of his associates is conditioned by the picture of those short intervals in which seizures occur. In consequence, he often becomes an object of solicitude. Or he may be left as a detached unit of the social picture in which he finds himself. This anomalous position and its relation to various problems, as well as the high mortality rate of the disorder, indicate the importance of the affliction from the point of view both of the individual and of society.

EPILEPSY IN MICHIGAN

The purpose of the present paper is to analyze the data relating to epilepsy in the state of Michigan, with special reference to factors of significance to public health, medical research, social welfare, state administration, education, mental hygiene, and general public welfare. Naturally, it is not possible for a study of this length to exhaust the field, but the aim is to offer data that may be of value in the further study of the many problems that epilepsy presents.

Material was obtained from the following institutions: (1) the state colony for epileptics; (2) the state hospitals for mental disorders; (3) the institutions for the mentally defective; (4) the penal institutions; and (5) the county infirmaries. In addition, a study was made of the general population in one section of the state, to obtain data relating to epilepsy in the general population.

At the state colony for epileptics data were obtained from the family and personal histories of the patients and from the medical case records of the institution's staff. Virtually all the cases here are of the major type if the three symptoms, unconsciousness, spasm of the muscles, and stupor, or sleep, are to be accepted as criteria.

Data relating to epileptics in hospitals for mental disorders were obtained from the medical case records of the Ypsi-

lanti, Kalamazoo, Pontiac, Traverse City, Newberry, Eloise, and Ionia hospitals as certified by the medical superintendent of each institution.

In the institutions for the mentally defective, the Michigan Home and Training School at Lapeer and the Training School at Northville, data were obtained from the medical records of the institutions.

The penal institutions at Jackson, Ionia, and Marquette had adequate medical records from which the desired data could be obtained.

In the case of county infirmaries, data were obtained from the records of the superintendents of the poor. While not a reliable source, it was the only one available.

In an attempt to arrive at the extent of epilepsy in the general population, a thorough survey was made of nine counties in the northeastern portion of the lower peninsula. This section was selected because of excellent contacts with individuals, officials, agencies, and so forth. Because epilepsy is often regarded as a disgrace, families attempt to hide its presence within the relationship. For this reason the approach to a survey of epilepsy must be carried on along lines different from those ordinarily followed in surveys of disease. In this study, information was obtained from physicians, health agencies, nurses, social workers, probate judges, school commissioners, teachers, clergymen, old residents, and members of county child-health committees. These child-health committees are composed of at least three women from each township in a county and they were an excellent source of information. Any cases not reported by a physician were rechecked to verify the affliction as epilepsy. Wherever doubt existed, the case was not accepted as epilepsy.

The Michigan Farm Colony for Epileptics—This colony was established under authority of Act 173, P.A. 1913, "for the humane, curative, scientific, and economical treatment of epileptic persons, exclusive of the insane and idiotic." The site, consisting of 1,510 acres of land, is located at Wahjamega in Tuscola County, four miles from Caro and eleven miles from Vassar. The institution has a receiving hospital and nine cottages for patients with a total capacity to care for slightly less than 1,000 persons.

The average population of the institution has ranged from 135 in 1915, the first full hospital year, to 856 in 1932. At the time of this study, there were 1,002 residence and vacation patients in the institution, of whom 78 had been there less than one year, and 189 more than one year, but less than two years. An analysis on a basis of five-year periods (Table I) gives a perspective of the tenure of residence of the colony group as a whole.

In analyzing the table, consideration must be given to the fact that the institution is not a long-established one. However, the fact that 35 per cent of the patients had been resi-

TABLE I.—RESIDENCE OF PATIENTS IN MICHIGAN FARM COLONY FOR EPILEPTICS, BY FIVE-YEAR PERIODS

Residence	*Number of patients*	*Per cent of total*
Less than 5 years	433	43
5 to 9 years	218	22
10 to 14 years	208	21
15 to 19 years	143	14
Total	1,002	100

dents for ten years or more would indicate that the colony provides a congenial, kindly, homelike atmosphere where the epileptic may live in an environment to which he can permanently adapt himself.

Various classifications of the epilepsies have been made on an etiological basis. At the Michigan Farm Colony, entering patients, after a complete examination, are classified into four types. Of the patients in the colony at the time of the study, 85 per cent were classed as idiopathic, 7 per cent as traumatic, 5 per cent as symptomatic, and 3 per cent as hereditary.

A study of the marital condition of these colony patients (Table II) shows that 82 per cent were single, 11.5 per cent married, 2.6 per cent widowed, 3.5 per cent divorced, and 0.4 per cent separated.

Analysis revealed a disproportionately higher number of females than of males among the married, widowed, and divorced groups.

The composition of a colony population is dependent somewhat upon the ability of the institution to provide for the

various patients of different ages. At the Michigan Farm Colony inadequacy of plant and of personnel makes it impossible to institutionalize more than a limited number of children, especially children under ten years of age.

Division into age periods (Table III) was based on the age of the patient at the nearest birthday.

Specifically, the figures indicate the need of facilities at the Michigan Farm Colony for caring for patients in the lower age groups.

Because records relating to levels of intelligence were not available, it was not possible to study the comparative intel-

TABLE II.—CIVIL STATUS OF PATIENTS AT MICHIGAN FARM COLONY

Civil status	*Number of patients*	*Per cent of total*
Single	821	82.0
Married	115	11.5
Widowed	27	2.6
Divorced	35	3.5
Separated	4	0.4
Total	1,002	100.0

TABLE III.—AGE DISTRIBUTION OF MICHIGAN FARM COLONY POPULATION AS COMPARED WITH GENERAL POPULATION AND ALL EPILEPTICS IN INSTITUTIONS IN U. S., 1923

Age group	*Number of patients in colony*	*Per cent of total*	*Per cent of epileptics in institutions in U. S., 1923*	*Per cent of general population*
Under 5 years	3	0.3	0.3	9.6
5 to 9 years	16	1.6	2.2	10.1
10 to 14 years	51	5.1	7.3	9.4
15 to 19 years	111	11.0	10.0	8.6
20 to 24 years	133	13.3	12.3	8.6
25 to 29 years	116	11.6	11.2	8.6
30 to 34 years	121	12.0	11.8	8.1
35 to 44 years	176	17.6	20.2	15.1
45 to 54 years	147	14.7	14.4	10.3
55 to 64 years	93	9.3	6.4	6.4
65 to 74 years	28	2.8	1.9*	3.7
75 years and over	4	0.4	1.6†	1.5
Unknown	3	0.3	0.5	0.1
Total	1,002	100.0	100.0	100.0

* 65 to 69 years.
† 70 years and over.

ligence ratings of the colony patients. However, data relating to educational attainment were analyzed and evaluated on a basis of grade completed. It is recognized that this criterion is not the most desirable one, but it serves to give a general picture of the extent of education among epileptics.

Of the 963 patients at the colony whose educational history was obtained, 21.9 per cent had received no formal education whatever, 69.3 per cent left school some time during the first eight grades, 8.8 per cent went beyond the eighth grade, and less than 1 per cent (0.8) went beyond high school.

Two factors must be borne in mind in considering the educational attainment of these people. First, because of the nature of his disorder, the epileptic does not find the school a congenial place; hence there is little that attracts him to stay there. Secondly, as will be presented later, mental deficiency and mental deterioration are associates of the syndrome of epilepsy.

Analysis revealed that those counties that had active social agencies, both official and voluntary, had a proportionately greater number of patients at the farm colony than the counties without active agencies. The necessity for institutionalizing certain epileptics seems to be realized by too few of the general citizenry.

The composite rate for the state was 27 per 100,000 of the general population.

Of the colony population, 90.5 per cent were native born and 9.5 per cent were foreign born. When these figures are compared with those of Michigan's general population, of which 82 per cent are native born and 18 per cent foreign born, there would appear to be some significance in the variation, but, because of the large number of variables operative, there is actually very little significance. Epilepsy is largely a disorder of the young and but few of the foreign born are in the age groups under forty years.

In analyzing the significance of position in the family in relation to epilepsy, data showed that in the smaller family groups of two, three, four, and five children there appeared to be a tendency for the epileptic to be the first-born, but there is not sufficient evidence to attribute this tendency to anything more than mere chance. Possibly further study, taking all

variables into account, may attach some significance to this factor.

A study of the occupations of the fathers of the colony patients gave an indication of the economic status of these patients. In general, this group of fathers was composed largely of common laborers, semi-skilled and skilled wage earners, farmers, and tradesmen. A few professional and business men make up the remainder. On the whole, the group was fairly representative of the lower-income group in the general population.

In analyzing family histories it must be recognized that the information given is very often incomplete and inaccurate.

TABLE IV.—FREQUENCY OF EPILEPSY AND DISORDERS POSSIBLY ALLIED TO EPILEPSY IN FAMILY HISTORIES OF 452 PATIENTS

Disorder	*Number of occurrences in family histories*
Epilepsy	236
Insanity	122
Feeblemindedness	91
Chorea	4
Paralysis	22
Migraine	82
Extreme nervousness	32
Syphilis	14
Deafness, muteness, or blindness	34
Alcoholism	55

This was a factor considered in the study of the family histories of these patients, and in 185 cases the histories were rejected for one reason or another. Of the remaining 817 cases, 365, or 44.7 per cent, gave negative family histories.

The disorders reported in the family histories of the remaining 452 are listed in Table IV.

This table would seem to indicate that among epileptics, epilepsy appears more frequently in the family history than any of the other disorders listed. However, there is the possibility that only institutionalized cases of insanity and only cases of extreme feeblemindedness, or idiocy, are usually recorded in histories.

Syphilis, which is often thought to be associated with family histories of epilepsy, appeared but 14 times in these histories.

Alcoholism also does not appear of much importance here. When only 55 cases appeared in the family histories of 817 epileptics, alcoholism can hardly be considered a likely causative factor. A better interpretation might be that alcoholism is evidence of an unstable or inadequate personality make-up and thus indicates a more fundamental factor as being of possible consequence.

Epilepsy itself, insanity, and feeblemindedness occur with sufficient frequency to suggest that possibly a generally unstable or sensitive nervous system is the basic factor in the

TABLE V.—AGE OF FIRST SEIZURE OF 919 PATIENTS IN MICHIGAN FARM COLONY

Age periods	*Number of patients*	*Per cent of total*
Under 5 years	292	31.8
5 to 9	133	14.5
10 to 14	197	21.4
15 to 19	145	15.8
20 to 24	56	6.1
25 to 29	52	5.6
30 to 34	19	2.1
35 to 44	17	1.9
45 to 59	8	0.8
Total	919	100.0

transmission of a condition which manifests itself in the syndrome known as epilepsy.

The data failed to show any appreciable general differences in the family histories of male and of female patients as regards these disorders. They did tend to show, however, that maternal disorders of this type are apt to manifest themselves more often than paternal defects, which is in general agreement with the findings of Thom.[1]

Of the 1,002 patients at the farm colony, 163, or 16.3 per cent, had a family history of epilepsy. Possibly the actual percentage is higher than this, but it will hardly compare with the percentage obtained by Gowers, who reported two-thirds in his study.[2]

[1] "Epilepsy," by Douglas A. Thom, M.D. *Boston Medical and Surgical Journal*, Vol. 187, pp. 320–24, August 31, 1922.

[2] *Epilepsy and Other Chronic Convulsive Diseases; Their Causes, Symptoms, and Treatment*, by W. R. Gowers. London: 1901.

Of the patients at the colony, 58 per cent had negative histories so far as concerned physical disorders. As a whole, the histories of the remaining 42 per cent indicated that the physical disorders were closely identical with those found in the general population, with one noteworthy exception. It was observed that the incidence of disorders of the nervous system and of the special sense organs was unusually high. Thus, a total of 85 cases of paralysis, meningitis, and chorea were recorded and a total of 15 cases of deafness and blindness. This may indicate a relationship to the unstable or sensitive nervous system previously suggested.

TABLE VI.—FREQUENCY OF SEIZURES IN PATIENTS IN MICHIGAN FARM COLONY *

Frequency of seizure	*Number of patients*			*Per cent of total*
	Male	Female	Total	
More than 10 a day	6	4	10	1.0
2 to 10 a day	41	28	69	7.3
Daily	35	32	67	7.1
5 to 20 a month	79	61	140	14.7
2 to 4 a month	164	165	329	34.7
1 every month	130	142	272	28.7
1 every 2 months	9	6	15	1.6
1 to 5 a year	16	30	46	4.9
Total	480	468	948	100.0

* In 54 cases—49 males and 5 females—there was no record as to frequency of seizure.

Although the majority of colony patients were adults, it appeared that the onset of epilepsy occurred during childhood or youth.

Satisfactory data were available for 919 patients (Table V).

Taken by age periods, 31.8 per cent of the colony patients had their first epileptic seizures before the age of five. Further, in 83.5 per cent of the cases the onset of the disorder occurred before the twentieth year.

In general, the onset of the disorder was slightly earlier in patients with a family history of epilepsy than in the general colony population.

The frequency of seizures covered a wide range, but an arbitrary classification of eight categories was set up to per-

mit an analysis of the question. The data on this point are summarized in Table VI.

Unquestionably, institutionalized epileptics have a greater frequency of seizures than non-institutional epileptics because of the tendency to care for epileptics at home as long as seizures are not too frequent. However, as soon as they become more and more frequent, efforts are made to have the person

TABLE VII.—DEATH RATE OF POPULATION OF MICHIGAN FARM COLONY, 1915–1932

Year	*Average population*	*Deaths*	*Death rate (per 1,000)*
1915	135	8	59.2
1916	193	13	67.3
1917	335	60	179.1
1918	395	78	197.4
1919	477	68	167.7
1920	504	69	136.9
1921	544	41	75.3
1922	661	29	43.8
1923	659	53	80.4
1924	699	62	88.7
1925	734	49	66.7
1926	837	62	84.4
1927	849	60	70.6
1928	833	69	82.8
1929	784	69	88.0
1930	789	54	68.4
1931	819	76	82.8
1932	856	65	75.9
	11,103	985	88.7

institutionalized, partly in the hope of alleviating the condition and partly because the burden of care becomes too great for the home.

The death rate for the institution, in common with hospitals of this type, is exceedingly high. The range of rates per 1,000 patients, from 1915 to 1932 inclusive, varies from 197.4 in 1918 to 43.8 in 1922, with an average over the eighteen-year period of 88.7 per 1,000 patients (Table VII). During the last ten years, with a larger average population, the institution tends to have a more uniform rate of about 80 per 1,000 patients.

Presenting this data in somewhat tangible form based on

age groups and distribution per 1,000 deaths, Table VIII indicates that the institutionalized group at Wahjamega generally does not reach an advanced age, since 80.8 per cent died before the age of fifty-five. For contrast, the distribution by age of deaths per 1,000 in the population at large is presented. This comparison places additional emphasis on the deaths in the colony group at a relatively early age. Adjusted to standard populations, this tendency would be brought out

TABLE VIII.—AGE AT TIME OF DEATH OF PATIENTS IN MICHIGAN FARM COLONY * AS COMPARED WITH GENERAL POPULATION AND POPULATION OF INSTITUTIONS FOR EPILEPTICS, 1923

Age	*Number of patients in colony*	*Distribution per 1,000*		
		In colony	In general population	In U. S. institutions for epileptics
Under 5 years	1	0.9	148.6	12
5 to 9	5	4.7	18.0	34
10 to 14	23	21.4	13.5	52
15 to 19	76	70.8	23.6	107
20 to 24	140	130.1	31.7	81
25 to 29	144	133.8	32.4	96
30 to 34	119	110.3	33.3	86
35 to 44	192	178.5	86.4	179
45 to 54	169	157.1	112.8	144
55 to 64	113	105.	142.3	91†
65 to 74	68	63.2	174.2	34
75 years and over	24	22.3	181.5	53‡
Unknown	2	1.8	1.6	29
Total	1,076			

* Including 91 deaths in the first ten months of 1933.
† Sixty-five to 69 years.
‡ Seventy years and over.

in a more pronounced form since the colony population shows but 7 per cent under fifteen years of age, whereas the general population is composed of 29 per cent under fifteen years of age.

Perhaps a more suitable comparison is made with the age distribution of patients who died in institutions for epileptics in the United States, as recorded in the census of 1923. It may be recalled that the general United States epileptic census for 1923 agrees rather closely with the composition of the Michigan colony population.

The 1923 report showed 205 of each 1,000 deaths in institutions for epileptics to be under twenty years of age, as compared with 97.8 for the Wahjamega group. However, innumerable variables, such as the severity of the condition of patients, would modify the picture. Both groups indicate that in general institutionalized epileptics do not reach an advanced age.

A study of the period of time over which the patient had been institutionalized at the time of death reveals (Table IX)

TABLE IX.—YEARS OF RESIDENCE AT TIME OF DEATH OF 1,076 PATIENTS IN MICHIGAN FARM COLONY

Years of residence	*Number of patients*	*Per cent*
Less than 1 year	225	20.9
Less than 5 years	659	61.2
5 to 9 years	272	25.3
10 to 14 years	123	11.5
15 to 17 years	22	2.0

that 20.9 per cent had been hospitalized less than one year; further, that 61.2 per cent had been institutionalized less than five years at the time of death.

A general interpretation would suggest that too often no attempt is made to institutionalize epileptic persons until it is too late for them to benefit from institutional care.

The period of time over which seizures had extended at the time of death is of social and economic significance (Table X). Data showed that no patients had had seizures for less than two years and that one person had had seizures over a period of seventy-seven years at the time of death.

In Table X the data on this point are distributed by five-year periods. Of the 611 cases on which definite data were available, 37.3 per cent had had seizures for twenty-five years or more at the time of death and 70.7 per cent had had seizures over a period of fifteen years or more.

Death certificates, giving the cause of death in 1,061 cases,[1] listed epilepsy as the primary cause in 646, or 60.9 per cent. (See Table XI.) This rather contradicts the opinion held by many that epileptics do not die of epilepsy as a direct cause.

[1] In 15 cases the cause of death was unascertained.

Of the 415 deaths from primary causes other than epilepsy, epilepsy was given as a contributing cause of death in 146, or 13.7 per cent of the total 1,061. Thus, according to the death certificates, epilepsy was either a primary or a contributing cause in 74.6 per cent of all deaths.

The principal causes of death other than epilepsy are listed in Table XII. The specific death rates for these are unusually high, due in part to the age distribution in the colony population and to the general lowered physical tone of a large number of the colony population. Other factors may be operative, but with our present knowledge the relationship is not clear.

TABLE X.—PERIOD OVER WHICH SEIZURES HAD EXTENDED AT TIME OF DEATH OF PATIENTS * IN MICHIGAN FARM COLONY

Period of seizures	*Number of patients*	*Per cent of total*
Less than 5 years	20	3.3
5–9	61	10.0
10–14	98	16.0
15–19	102	16.7
20–24	102	16.7
25–29	54	8.8
30–34	53	8.7
35–44	54	8.8
45–54	41	6.7
55–64	14	2.3
65–74	11	1.8
75 and over	1	0.2
Total	611	100.0

* Not including 565 cases on which definite data were not available.

The lack of general facilities at the colony makes it impossible to admit epileptic persons immediately upon commitment. The waiting list at the time of study (1933) consisted of a total of 243 commitments from the general population (152 males and 91 females). At the same time various state institutions in Michigan had a total of 332 patients—186 males and 146 females—awaiting transfer to the colony.

The distribution of ages in the colony waiting list ranged from one year to eighty-one years, 45.5 per cent being under fifteen years of age as compared with 7 per cent in the colony population. Further, 62.3 per cent were under twenty years

of age as compared with 18 per cent in the colony population. The lack of facilities at the colony for giving special care to the younger age group explains, in a large measure, the disproportionately large number in the lower age groupings of the waiting list.

Of the 243 commitments directly from the state at large, 44 per cent had had their names on the colony waiting list for less than one year, while 56 per cent had been listed more than a year. Further, analysis revealed that 24.3 per cent

TABLE XI.—DEATHS DUE TO EPILEPSY AMONG 1,061 PATIENTS IN MICHIGAN FARM COLONY

Cause of death	*Number of deaths*	*Per cent of all deaths*
Epileptic degeneration	376	35.5
Status epilepticus	137	12.9
Died during seizure	105	9.9
Exhaustion following seizure	28	2.6
Total	646	60.9

had been on the waiting list more than three years and that 6.6 per cent had been listed for more than five years. Six commitments had been on the waiting list for more than six years.

Incidence of Epilepsy in State Institutions.—The incidence of epilepsy in state institutions throws some interesting light on epilepsy among special groups. A survey of seven hospitals for mental disorders, with a combined population of 12,597, revealed 221 cases diagnosed as epileptics by the medical staffs of these institutions. The incidence of epilepsy in the combined hospital population was 1,754 per 100,000, or 1.8 per cent. The incidence in each separate institution in this group varied but little from this rate with one exception—the hospital for the criminally insane. This institution had an incidence of epilepsy of 3,079 per 100,000, or 3 per cent.

The home and training school at Lapeer had a population of 3,460 at the time of the survey. This institution cares for mental defectives of all classifications and grades, a large percentage being in the idiot and imbecile classes. The Lapeer training school had a total of 309 epileptics in its population and an incidence of 8,931 per 100,000, or 8.9 per cent.

The training school at Northville admits only subnormals with intelligence quotients between 60 and 80. Thus the group is composed of the higher type of subnormals. This institution, at the time of the survey, had a population of 703, of which six were epileptics.

Analysis showed that the incidence of epilepsy in Lapeer was 8,931 per 100,000, or 8.9 per cent, and the incidence at Northville 853 per 100,000, or 0.8 per cent. Thus the group of higher-grade subnormals had a much lower incidence of epilepsy than the group of lower-grade subnormals. As we have observed, epilepsy itself may have a retarding effect upon the mentality, thus being a factor that tends toward a lower-

TABLE XII.—PRINCIPAL CAUSES OF DEATH OTHER THAN EPILEPSY AMONG 1,061 PATIENTS IN MICHIGAN FARM COLONY *

Cause of death	*Number of deaths*	*Rate per 100,000*
Pneumonia	104	936
Diseases of the heart	87	783
Tuberculosis	66	594
Nephritis	28	252
Cerebral hemorrhage	26	234

* Population 11,103.

grade mentality in many cases, yet the high incidence at Lapeer seems to indicate that the disease is rather closely associated with a generally defective nervous system.

Three state prisons were surveyed to determine the incidence of epilepsy in the prison population. The incidence for the three separate prisons varied but little. The combined population of the three was 7,480 with a total of 19 epileptics, an incidence of 254 per 100,000. This figure no doubt is a fairly close indication of the extent of epilepsy in Michigan's prison population. Whether it expresses the situation in the criminal class in general is a question that will have to await further study. Certainly, it does not support the opinion held by many that a disproportionately large number of epileptics are to be found in prisons.

The 72 county infirmaries from which data were obtained had a population of 9,655, and a total of 85 epileptic persons, giving an incidence of 829 per 100,000 inmates or 0.8 per cent for the infirmary population.

Epilepsy in the General Population.—In order to obtain data relating to the general situation in regard to epilepsy in the state of Michigan, a thorough survey was made of nine counties in the northeastern section of the lower peninsula. These counties were selected because of excellent contacts with individuals and agencies in a position to be of direct assistance in the survey. In addition, this area has a fairly constant population,[1] and the nature of the population is satisfactory for the purposes of a general survey. About two-thirds of the population may be termed as indigenous, with

TABLE XIII.—INCIDENCE OF EPILEPSY IN VARIOUS INSTITUTIONS AND IN THE NINE-COUNTY AREA SURVEYED

	Rate per 100,000
In nine-county area	210
In penal institutions	254
In all hospitals for mental disorders	1,754
In hospital for the criminally insane	3,079
In home for low-grade mental defectives	8,931
In home for high-grade subnormals	853
In county infirmaries	829

the remaining one-third composed largely of Polish, Canadian, and Scandinavian immigrants and their families.

Data were rechecked to insure maximum of accuracy in all respects.

The survey showed that these counties had a total of 46 epileptic persons committed to state institutions (including two persons on the farm-colony waiting list). In the population at large there were 108 definitely epileptic persons, giving the entire area a total of 154 epileptics. On the basis of a population of 73,056, the general incidence of epilepsy would be 210 per 100,000, or 0.2 per cent for this area.

Of the cases of epilepsy in the population at large, 62 per cent were or had been under medical care.

The sex incidence in this group of epileptics was males 53.9 per cent, females 46.1 per cent. This ratio may be compared with the findings of Gowers [2] (males 48 per cent and females 52 per cent); of Patrick and Levy [3] (males 62 per

[1] It had a slight decline from 80,816 in 1900 to 73,056 in 1930.

[2] See note 2, page 450.

[3] "Early Convulsions in Epileptics and Others," by H. T. Patrick, M.D.,

cent and females 38 per cent); and of Spratling [1] (males 60.1 per cent and females 39.9 per cent).

To obtain a comparative study of the incidence of epilepsy among special types or groups of people in relation to the incidence of epilepsy in the general population, a composite analysis was made. This is shown in Table XIII.

From this analysis it appears that the incidence of epilepsy in the general population is less than that in any group studied. However, the incidence of epilepsy in penal institutions was but slightly higher than that of the general population.

TABLE XIV.—ESTIMATE OF EPILEPTIC PERSONS IN MICHIGAN

	Number	*Per cent of total*
In epileptic colony	1,002	9.9
On colony waiting list (in general population)	243	2.4
In hospitals for mental disorders	221	2.1
In homes for mental defectives	315	3.0
In penal institutions	19	0.2
In county infirmaries	85	0.8
In population at large	8,281	81.5
Total	10,166	99.9

An application of the rate found in the nine-county area to the state of Michigan as a whole would indicate that there are approximately 10,166 epileptic persons in the entire state. Table XIV gives an approximation of the distribution on this basis.

SUMMARY

1. The average population of the Michigan Farm Colony for Epileptics varied from 135 in 1915 (the first complete institution year) to 856 in 1932. The colony population is dependent upon the facilities available at the colony and not upon the incidence of epilepsy in the general population.

2. Of the 1,002 colony patients in August, 1933, 43 per cent had been residents at the colony for less than five years, 22 per cent from five to nine years, 21 per cent from ten to fourteen years, 14 per cent from fifteen to nineteen years. That 35 per cent of the patients had been in residence ten years or

and D. M. Levy, M.D. *Journal of American Medical Association*, Vol. 82, pp. 375–81, Feb. 2, 1924.

[1] *Epilepsy and Its Treatment*, by W. P. Spratling, M.D. Philadephia: W. B. Saunders and Company, 1904.

more is an indication of the advantages of colony care in providing an environment to which the epileptic can adjust himself permanently.

3. In regard to the civil status of colony epileptics, data showed that 82 per cent were single. A proportionately higher number of females than of males were found in the married, widowed, and divorced groups. The indication is that male epileptics are less likely to marry than female epileptics, possibly because of the extreme insecurity of the male epileptic in the economic world.

4. Staff diagnosis as to types of epilepsy showed 85 per cent idiopathic, 7 per cent traumatic, 5 per cent symptomatic, and 3 per cent hereditary.

5. Only 7 per cent of the colony patients were under fifteen years of age while 80.2 per cent were between the ages of fifteen and fifty-five. This light distribution in the lower age groups was largely due to a lack of facilities at the colony for caring for children.

6. A total of 21.9 per cent of the patients had received no formal education before admission to the colony and 91.2 per cent of the entire group had not entered high school. The low educational attainment of this group may be attributed to the frequent association of mental deficiency with epilepsy and also to the fact that because of his affliction the epileptic does not find school a very congenial place.

7. In general, counties with well-established social agencies were apt to have a proportionately higher number of persons at the colony than those without such agencies. The general rate for the state was 27 patients per 100,000 of the general population.

8. The position of the patient in the family and the size of the family seemed to have no particular significance.

9. The occupations of the fathers of the patients indicated that, as a whole, the patients were fairly representative of the lower-income group in the general population.

10. No appreciable differences were found in the family histories of male as against female patients in regard to such disorders as epilepsy, feeblemindedness, insanity, chorea, and so forth.

11. Data showed that maternal disorders or defects of this

type tended to manifest themselves more often than paternal disorders.

12. In the family histories, epilepsy appeared more often than any other disorder, 16.3 per cent of the patients having a family history of epilepsy.

13. Feeblemindedness and insanity appeared of significance in the family histories, suggesting the association of epilepsy with deficient and unstable nervous systems.

14. Syphilis and alcoholism, contrary to public opinion, appeared to be unimportant.

15. The histories of patients previous to admission to the colony showed an unusually high frequency of disorders of the nervous system and of special sense organs. A tendency toward defective nervous systems is again suggested.

16. Of the 919 colony patients for whom data on this point were available, 31.8 per cent had had their first seizure before the age of five and 83.5 per cent had had it before the age of twenty, suggesting an early onset of epilepsy. The social and economic importance of this factor is significant.

17. The factor of sex appeared to be of no significance in onset of seizures, frequency of seizures, family history, or patient history.

18. Patients with a family history of epilepsy showed no significant variation from the general colony group as regards age of onset and frequency of seizures, possibly suggesting that epilepsy classified as "hereditary" is not essentially different from any other epilepsy, the mere fact of epilepsy in the family history being the sole basis for this classification.

19. An unusually high death rate and a relatively short life appeared to be characteristic of institutionalized epileptics.

20. At the time of death, 20.9 per cent of the patients who had died had been institutionalized less than one year and 61.2 per cent had been institutionalized less than five years. The added fact that 15.4 per cent of the patients had one or more seizures per day at the time of admission to the institution suggests that too often people turn to colony care as a last resort and only after the problem has become too difficult for the home.

21. A total of 60.9 per cent of the death certificates listed epilepsy as the primary cause of death, and of the remaining, 34.9 per cent had epilepsy listed as a contributing cause of death, indicating that despite popular opinion to the contrary, a large proportion of epileptics die as a result of epilepsy.

22. Of the waiting list of 575—243 committed from counties and 332 awaiting transfer from other state institutions—45.5 per cent were under fifteen years of age, indicating a lack of facilities for the care of epileptic persons in the lower age groups. In addition, of the direct county commitments on the waiting list, 56 per cent had been on the list for more than one year and 6.6 per cent had been listed for more than five years, an indication of a general lack of adequate provision for epileptic persons in need of institutional care.

23. A survey of a nine-county area in the northeastern section of the lower peninsula revealed an incidence of epilepsy of 210 per 100,000 population and a sex incidence for this group of epileptics of 53.9 per cent males and 46.1 per cent females. Of the epileptics in the general population, 62 per cent were or had been under medical care.

24. The incidence of epilepsy per 100,000 for various groups and institutions in the state was as follows: In general state population, 210 [1]; in penal institutions, 254; in home for high-grade mental subnormals, 853; in county infirmaries, 829; in hospitals for mental disorders, 1,754; in hospitals for the criminally insane, 3,079; in home for low-grade mental defectives, 8,931. The evidence here is that among the criminal class epilepsy is not as prevalent as is so often asserted. Further, the association of a defective nervous system with epilepsy is emphasized.

25. Estimated on the basis of an incidence of 210 per 100,000 and a population of 4,842,000, the number of epileptic persons in the state of Michigan at the time of this study was 10,166. Of these, 9.9 per cent were under colony care; 2.4 per cent were on the colony waiting list, but living in general society; 2.1 per cent were in state hospitals for mental disorders; 3 per cent were in homes for mental defectivs; 0.2 per cent were in penal institutions; 0.8 per cent were in county infirmaries; and 81.5 per cent were in the community.

[1] Based upon the nine-county survey.

THE MENTAL HEALTH OF CHILDREN OF DEMENTIA-PRAECOX STOCK

SECOND REPORT

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IN 1922 Thom and Walker reported from their study of the offspring of epileptics the following heartening conclusions:[1]

> "1. Epilepsy as a disease is not transmitted directly from parent to offspring; rather we believe that it is a nervous system lacking in normal stability that is inherited, and the manifestations of this instability may be mental deficiency of all degrees, insanity of various types, neurological and psychopathic disorders, or convulsions from various existing causes that would have little or no effect on a normally developed nervous system.
>
> "2. These mental and nervous disorders are less frequently found in the offspring of a so-called epileptic than we have heretofore believed, and the future of the offspring born of epileptic parents is not so hopeless as pessimistic authorities on heredity record.
>
> "3. Maternal defects are more frequently manifested in some form or other in the offspring than are paternal defects, and when present are likely to appear at an earlier age.
>
> "4. It was found that in only a few cases were we dealing with pure cultures of epilepsy. In most instances contamination was brought about by some defect in the other partner, such as feeblemindedness, insanity, alcohol, and syphilis.
>
> "5. In this study it was found that convulsive disorders were more frequently found in the offspring of the organic group as compared with the idiopathic group. The organic group is, however, so small that too much consideration should not be given to this point. It should, nevertheless, stimulate further inquiry relative to the offspring of normal individuals and a larger group of organic cases.
>
> "6. This study indicates the necessity of research relative to the transmissibility of genetic defects in both epilepsy and psychiatry. We feel that dogmatism regarding this aspect of mental diseases has not been justified."

[1] See "Epilepsy in the Offspring of Epileptics," by D. A. Thom, M.D., and Gerna S. Walker. *American Journal of Psychiatry*, Vol. 1, April, 1922. p. 620.

It was thought that as a foil to Dr. Thom's study on epileptics, it would be of interest to look into another group, this time a psychotic group, and see how it fared with the offspring of the dementia-praecox patient. Accordingly, Miss Rosamond Clark took the responsibility of personally visiting the homes, or pseudo-homes—often broken or limping when one parent was in a hospital—to gain first-hand information concerning the age, sex, education, environment, and physical and mental health of the children of a group of such patients.

The results of the study were summarized as follows:[1]

> "1. One thousand names of patients with the single diagnosis of dementia praecox were taken alphabetically from the Boston Psychopathic Hospital index discharge cards.
>
> "2. Nine hundred and twenty-five were of marriageable age. Two hundred and seventy-five married (5 twice), and of this number 194 were women.
>
> "3. These individuals were nearly all in the laboring class, usually in the less skilled occupations. Many of them were foreign born. Their offspring are of a slightly higher occupational level.
>
> "4. The final analysis rests on an investigation of 381 children (4 of whom have since died), the offspring of 136 matings.
>
> "5. Of the 381 children, 86 deviate from the normal either mentally, physically, or socially.
>
> "6. Of the 86 deviators, the mother had been a patient in 74 cases, the father in 12 cases.
>
> "7. Of the 295 normal children, patients were the mothers in the case of 250 of the offspring, the fathers in the case of 45.
>
> "8. The majority of the 381 children, if of school age, are in school regardless of their deviations. Those of older years are for the most part engaged in gainful occupations.
>
> "9. The deviators consist of 5 dementia-praecox patients, 4 feeble-minded, 12 backward, 12 nervous, 17 physically diseased, and 36 cases of conduct disorders, a total of 86; 58 were under sixteen years of age, 28 over sixteen years.
>
> "10. The final conclusion remains in *statu quo*, since the 295 normals may show symptoms later, 234, or 79 per cent, being under sixteen, 61, or 21 per cent, over sixteen; *but to date they have shown none of the symptoms under discussion.*
>
> "11. The value of this work will best be shown if those of the 377 who are still living are visited again in 1925 and in 1930, at which time the stability of those who now seem normal will be either proven or disproven."

This paper brought the instant question, How about the offspring of normal parents? And again we took up the task

[1] *The Mental Health of 463 Children from Dementia-Praecox Stock*, by Myrtelle M. Canavan, M.D., and Rosamond Clark. MENTAL HYGIENE, Vol. 7, January, 1923. pp. 147–48.

of attempting an answer. This time we secured staff permission to interview the out-patients at the Peter Bent Brigham Hospital concerning their children. Miss Clark again did the visiting and rounding up of information. Our summary of this study[1] was as follows:

> "1. Data on 581 children, the offspring of 145 matings of non-psychotic parents, were collected from the Medical Out-door Department of the Peter Bent Brigham Hospital, Boston.
>
> "2. The parents were comparable to the parents in the dementia-praecox study in economic levels, nativity, and number of children per mating.
>
> "3. We have available data on 500 living children.
>
> "4. Of the 500 children, 145 deviate from the normal either mentally, physically, or socially. The deviators were: 1 dementia-praecox patient, 1 pre-praecox, 10 feebleminded children (1 with convulsions), 12 backward, 12 nervous, 8 cases of conduct disorders, and 101 physically diseased. One hundred children were under and 45 were over sixteen. Of the normal children, 224 were under sixteen, 131 over this age.
>
> "5. The majority of the 500 children of school age are in school or in gainful occupations.
>
> "6. The death rate of the non-psychotic offspring is lower than that of the dementia-praecox issue and considerably lower than that of the epileptics.
>
> "7. The conduct disorders, though of the same types in the two groups, are 8 out of 500, or 1.6 per cent, for the non-psychotic offspring, and 36 out of 381, or 9.5 per cent, for the offspring of dementia-praecox parents. [Possibly more avenues of information open.] The number of backward and nervous is the same (12 cases) among the non-psychotics as among the dementia-praecox cases, though the percentage is less than in the former group. The greater number of physically diseased among the children of non-psychotics is hard to explain. It may be, however, that these non-psychotic parents take their children to the doctor more often than the psychotic parents, or for less important things. The diseases do not seem to be communicable in nature, rather they appear to be dietary, such as malnutrition and mild chronic infections, diseased tonsils, and now and then cardiac residuals of probable previous infections, but non-incapacitating.
>
> "8. One undoubted case of dementia praecox was found and is cared for as a committed case in a state hospital. One other is of praecox type, although she partly earns her living."

After these first two publications, other interests absorbed us, and nothing more was done until 1932, ten years after the gathering of the data on the dementia-praecox offspring, when a letter came inquiring whether we had ever made the

[1] *The Mental Health of 581 Offspring of Non-Psychotic Parents*, by Myrtelle M. Canavan, M.D., and Rosamond Clark. MENTAL HYGIENE, Vol. 7, October, 1923. pp. 777–78.

second report mentioned in the final sentence of our first study. Thus stimulated, we dusted off such papers as we had kept and scrutinized addresses. Ten years made for many changes in residence, especially where new arrangements had had to be made because of the absence from the home of one of the parents or the doubling up in living quarters when financial reverses became acute. Marriage of many of the female children added to the difficulty of locating the subjects of our study. In many cases letters of inquiry came back marked, "Moved; no address," or no answer was received at all. But sometimes social-services exchanges would yield a name, as would the courts or even the newspapers, and in spite of difficulties we secured news of 117 children of 44 of the original matings. Of the 44 parents who were mentally diseased, 7 were males and 37 females.

The ages of the 117 offspring were as follows:

Under 11.	10
11–20.	55
21–30.	44
31–40.	8

Of these 117, 9 were dead, leaving 108 living, 51 females and 57 males. Fifty-eight, or 53 per cent, of these 108 had at the time of the study presented no symptoms that called them to the attention of hospitals, courts, guardians, truant officers, and so forth. Of these 58, 34 were females, 24 males. The parent is the mother who was mentally diseased in 30 instances, the father in 6, rather a good showing for the management of the father left to keep the household together for varying periods. So often a father left with the care of a household has to call on some aged relative, who has been long out of touch with household duties and the care of minor children, or, when relatives are not available, is obliged to hire at a low wage the same type of aging or infirm woman. In any case, discipline is apt to be periodic and the children react accordingly. One-half of these 58 as yet normal individuals were still under twenty-one years of age, which gives pause in the prognosis. However, at the time of the study, all was well with them, as with the 29 who were over twenty-one years of age.

Of the 50 deviators, 3, with ages ranging from eighteen to

thirty-three, had been committed as insane. Two of these had the same type of mental disease as their mothers. The other, whose father was insane, was diagnosed manic-depressive on first admission and returned to the community after a period in the hospital. Summaries of these three cases follow:

Case 1.—J. G., an unmarried Jewish girl, came under observation in January, 1932, at twenty years of age. Her father had previously been under care at this hospital and at Westborough, but had been discharged and had a store in another state. One of his sisters is under state-hospital care.

This girl had gastrointestinal upsets in her childhood, but started school at the age of five and finished three years of high school. She attended night school for another year, but had some difficulty with her studies, thought to be due to poor health. She had temper tantrums and was hard to manage, but liked to be with the crowd for pleasure and excitement.

At eighteen and a half, she became pregnant and was delivered in April, 1931. The following Christmas she began to wonder why her friends did not call as usual or invite her out. She had found work during the holidays, but after Christmas she was laid off. She had always failed to keep any position long. She complained of constipation, thought she was sick, would not get up, refused food, became fearful, and thought that she had a cancer and was going to die. After ten days' observation she was transferred to Boston State Hospital.

She was later discharged as recovered from an attack of manic-depressive psychosis.

Case 2.—F. C., a laborer, single, aged twenty-five, came under observation June 4, 1924.

His father, also a laborer, drank, but was of a placid disposition. The mother was at Foxborough State Hospital. Two cousins were in state hospitals.

The patient was the eldest of six children. He had pneumonia at the age of three and enuresis from the age of seven to eight. He graduated from school at eighteen and held various jobs, but because of illnesses, six months was about as long as he could work at any given place.

He began masturbating at the age of twenty; he had heterosexual contacts also, and began drinking. He had been in court for vagrancy.

For the last few years he had wanted to be by himself. He could not confide in any one and was hallucinated and deluded. He was sent to Westborough as a case of dementia praecox.

Nine years later he was transferred to the Metropolitan Hospital where, in 1933, he was reported to be in fair condition, working daily on the grounds, though he had a mitral stenosis, which was compensated for, and now and then had to be on a special diet for sugar in the urine. It seemed that after nearly ten years under hospital care, he was an established institutional patient.

Case 3.—B. M. H., female, single, got along without hospital care until she was eighteen years of age. Early in life, when between eight

and ten, she had had tantrums. Her menstrual periods did not begin until she was seventeen.

She began school at five and in school was quite a leader. She finished high school, and thinking that she would learn to teach French, she went one semester to Boston University. During this school period she was without her mother, who was a patient in Psychopathic and Westborough hospitals until 1930.

At college she got such low marks that she became discouraged. Also family finances were insecure, so she stopped going. Then she thought that she would like to be a nurse. The hospital at which she applied did not accept her, however, and this had an unfavorable effect upon her.

In 1932 her father, a war veteran, who had been shell-shocked and gassed and was alcoholic, committed suicide. The next year, 1933, she spent with an older sister whose good qualities she admired. During this year she began to wear her oldest clothes, then would not get up, thought that people were coming to get her, that fire engines were coming. At the Boston Psychopathic she was quiet, even mute, uncoöperative, resistive. She was committed to Worcester as a dementia-praecox patient. From there she was sent out in family care, and in July, 1934, was employed to care for children at $6.00 a week. She remained only a few hours.

Fourteen of the 108 offspring were feebleminded or backward. In all of these cases the mothers had been the patients. Three of the offspring were nervous and 30 were physically diseased or exhibited conduct disorders. *In 47 of the 50 deviators, the mother was the patient.* This seems to mean that the mother's absence from the home, or abnormalities in her management when she is present (returned on visit or against advice), does have a decidedly deleterious influence in the development of untoward symptoms in the children.

A few examples follow in which there have been three or more children in the family, emphasizing the haphazardness of deviation.

1. Patient, dementia praecox, female.

One daughter, now thirty-two, was quite normal while in school, graduating at nineteen and having an average of 80 in all her studies. At twenty-two she had a period of nervous exhaustion, from which she has not yet recovered. She does housework at home for her living expenses. She has an aunt in Westborough State Hospital.

Another daughter, thirty years old, has been given up by relatives as hopeless (grave conduct disorder).

A third daughter, twenty-eight, is quite normal, works, and has a pleasant mental outlook.

2. Patient, dementia praecox, female.

A son died of tuberculosis at the age of seventeen.

A daughter, now twenty-three, after graduating at eighteen, worked until she married. She is considered very efficient and is popular.

A daughter, now twenty-two, is overweight and sensitive about it. At twelve she was seduced by an older relative. She has a lisping speech and strabismus of one eye. She left school at sixteen, while in the seventh grade, because of mental defect (moron). She works well (for $2.50 per week and board).

A daughter, now twenty, graduated at eighteen from high school, and works at home.

A daughter, eighteen, graduated at sixteen from high school. She will go to Simmons College.

A daughter, sixteen, goes to high school.

A daughter, fifteen, goes to high school.

A daughter, eleven, is in the seventh grade.

3. Patient, dementia praecox, female.

The husband is of very poor stock.

A son, nineteen, was at the Fernald School. His I.Q. was 73. His I.Q. improved under training, but now that he has left the school, he has no occupation.

A daughter, eighteen, is a case of conduct disorder. She runs away, plays truant, lies, and is disobedient, defiant, saucy, hard to get along with. She has an I.Q. of 81. She has been under observation in the out-patient clinic in a school for the feebleminded and at a Catholic home for delinquents.

A son, seventeen, escaped from a school for the feebleminded. He had an I.Q. of 74. He was untruthful, tricky, and evasive.

4. Patient, dementia praecox, female.

A daughter, thirty-three, finished high school at seventeen and worked in a clerical position until married. She has five children.

A daughter, thirty, finished high school and business school, and was employed until she married. She has two children.

A son, twenty-six, went through two years of high school. He now is a house painter and contractor.

5. Patient, dementia praecox, male.

A daughter, twenty-two, is a graduate of Lowell Teacher's College and wants to teach.

A daughter, twenty-one, went through two years of high school. She is now a mill operative.

A son, seventeen, is a senior in high school.

A daughter, thirteen, is in the first year of high school. She is interested in art.

A daughter, thirteen, in the first year of high school, is interested in teaching.

6. Patient, dementia praecox, female.[1]

A daughter, eighteen, graduated from high school at sixteen and a secretarial school at seventeen. She is now a private secretary. Noted as sedate.

A son, sixteen, is a junior in high school, with an average of 90 in his second year.

A son, thirteen, is in junior high school, B in all studies.

[1] She recovered after a pelvic operation and has had no recurrence.

A son, nine,[2] is in fifth grade. He sells magazines after school and is well liked.

A daughter, two,[2] is very strong and healthy, even talks in sentences.

For a rapid review and comparison, the items in the several studies have been brought together in tabular form:

COMPARISON OF CHILDREN OF EPILEPTIC PARENTS, PARENTS WITH DEMENTIA PRAECOX, AND NON-PSYCHOTIC PARENTS

	Epileptic parents		*Dementia-praecox parents*		*Non-psychotic parents*
	Echeverria study	Thom study	First Canavan study	Second Canavan study	Canavan study
Number of matings	136	117	136	44	145
Number of children	531	431	463	117	581
Normal	105	238	295	58	355
Died	222	151	86	9	81
Epileptic	78	14	0	0	0
Insane	11	2	5	3	2
Feebleminded	18	14	4	8	10
Backward	*	*	12	6	12
Nervous	*	*	12	3	12
Physically diseased	*	*	17	3	101
Cases of conduct disorder	*	*	36	27	8

* Information on this point not included in study.

SUMMARY

1. From the original matings with 463 offspring, 117 children from 44 of the original matings were located. Nine of these were dead.

2. Of the 108 living children, 58—34 females and 24 males, with ages ranging from two to forty—had up to the time of the study been normal.

3. Of the 50 deviators—33 males and 17 females, with ages ranging from twelve to forty—47 had insane mothers and 3 insane fathers.

4. Of the deviators, three had been committed to mental hospitals, two with a diagnosis of dementia praecox. The third, diagnosed as a manic-depressive, was sent home after the attack subsided.

5. Fourteen of the 50 were feebleminded or backward. Some were in and others out of schools for mental defect.

[2] Born after first study.

6. Three of the 50 were "nervous." One had had an attack of "nervous exhaustion," but did not go to a hospital.

7. Three were outstandingly physically diseased.

8. Twenty-seven presented problems of conduct disorder.

9. So far as we know, only 8, or 2 per cent, of the 377 children living at the time our first study was published have up to the present time become committedly insane. This may be too optimistic a conclusion, but we submit it on the supposition that news of commitment would be the easiest to gather, and we know of no more than these eight.

A MENTAL-HYGIENE SURVEY OF PROBLEM INDIAN CHILDREN IN OKLAHOMA

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DURING the late summer and autumn of 1935, the writer had opportunity to participate in a mental-hygiene survey among the Indian tribes of Oklahoma. This survey was initiated by the Bureau of Indian Affairs for the purpose of securing some definite bases for alterations in the educational facilities available to the Indians. The survey personnel consisted of the head of the division of boys' activities and the head of the division of health education from the bureau, two psychologists provided by the University of Oklahoma and the state teachers' colleges, and the writer, as physician and psychiatrist.

To make clear the existing situation with regard to the Indians in Oklahoma, it is necessary to include a brief historical statement. Eastern Oklahoma was formerly known as Indian Territory. From a time about one hundred years ago most of this region has been populated by members of the so-called Five Civilized Tribes. These tribes—the Cherokees, Creeks, Choctaws, Chickasaws, and Seminoles—came originally from the southeastern part of the United States. Their history is complicated and diverse, involving treaty after treaty with the United States. No sooner would they be settled in one area than it became necessary, because of the increasing invasion by whites, to make a re-allocation of land. For a long time each tribe held various parts of this region in a tribal or communal manner. Later land was taken back and allocated on an individual basis. This latter fact in part accounts for the known situation that vast numbers of the Indians have lost their land, and now exist on the most meager margins imaginable. Each tribe has had its own his-

tory, customs, and culture, although at the present time feelings of tribal solidarity seem to be lessening among the younger generation.

Among the earliest schools were those provided by religious denominations. Later on the federal government attempted to do a very great deal in the way of providing school facilities. Some thirty or forty years ago a considerable number of so-called boarding schools were established, financed directly or indirectly through government funds. These schools provide elementary education, and in a few cases afford a secondary education. Strenuous efforts were made to induce Indian parents to send their children to these schools. In the main the curriculum was not essentially different from that in schools for white children, although there has always been some endeavor to provide training in the domestic and manual arts. The schools are located in or near to such towns as Tahlequah, Eufaula, Hartshorn, Hugo, Millerton, Ardmore, and Sepulpa. Some of them are coeducational, some for only one sex. In the main, each has been limited to the members of one or two tribes occupying the surrounding territory.

Since by definite statement in the state constitution of Oklahoma Indians are to be considered as whites, Indian children may attend many public schools. Because so many Indian families still speak their native tongues, it follows that large numbers of children in public schools are without even a speaking knowledge of English. This results in apparent mental retardation by the time the children have reached the age of ten or twelve. The net outcome has been that practical results in the field of education have been much less than the apparent or theoretical ones.

There is no doubt that the boarding schools have done a tremendous and valuable piece of work. They have given excellent physical care in an environment in which consideration of the Indian children themselves is primary. They have not functioned to meet many of the needs as actually shown at the present time. Children attend for several years, learning academic subjects and participating in vocational work that is on a large scale on a departmentalized basis. Then many of them return to their extremely meager family house-

holds, unable to bridge the gap between their school life and their actual living conditions. Then, too, boarding schools can at the best accept only a small fraction (at present about 10 per cent) of the Indian children of school age. All of this has relation to the recognition of problems, and especially to the calling of this survey project.

A comparatively recent development in education in Oklahoma are the Indian day schools. These are set up in districts where there are enough Indian children to make a school feasible. The teachers are always at least part Indian. They have usually had at least some university training, and are successfully making the schools real centers for social and educational activities for the Indians of the communities in which they are located. Many of the experienced workers to whom the writer talked were of the opinion that the need of the present is specifically for more of these schools. Incidentally, many of the Indian families live only one or two in a district, so that Indian schools are impracticable.

A total of 235 problem cases were examined. School social workers and field education agents brought in to the selected centers the children who were not already present in the boarding schools. Each case was subjected to some physical and neurological examination, a psychiatric interview, and two or more psychological tests. These tests were in the main from the Pintner-Patterson performance tests, the non-language tests, the Goodenough drawing tests, the Otis self-administering tests, and the Stanford-Binet tests. Further investigation and conferences were held with teachers, social workers, and all others who knew of the social situation in question.

An earnest endeavor was made to arrive at some understanding of the nature of each child's problem. Such experience in individual disposition was given as could be, and the cases were classed as nearly as possible into the various large problem groups. It cannot be said that these cases represent a cross section of the Indian children of that area. The children were selected on the basis that they were problems. It must also be admitted that some of the most serious behavior cases, especially adolescents, could not be included because of their refusal to coöperate in the study. With due recogni-

tion of these limitations, it was felt that certain conclusions almost forced themselves to the attention of the examining group.

Probably the most outstanding finding was the relatively large number of children who have come to be considered as mental defectives, whereas their real difficulty is a lack of opportunity. They are those who have been deprived of an equal start in education, who show language handicap; or they are those who by reason of so-called manual-mindedness have been unable to adapt themselves to an academic curriculum. Approximately 75 out of the total group examined were believed to fall in this class. Strong recommendations were made for the establishment of an opportunity room in each boarding-school area where properly trained teachers could deal with these problems.

A group of about 30 appeared to be so defective as to be unable to adjust in the community. For these, recommendations were made for institutionalization in the state school for defectives, or, in certain cases, for referring them to a special colony to be developed in one of the government schools. It is anticipated that a considerable number of individuals of low-grade mentality may be more or less permanently segregated and given enough training to make them at least partially self-supporting and self-sustaining in a supervised project.

Some 20 cases of primary health conditions were uncovered. These included active tuberculosis, post-poliomyelitis, severe epilepsy, and so on. Of course an additional considerable number were found to be tuberculosis contact cases. It should be noted that health and hospital facilities are extremely limited in this whole region. Hospitals are often as far as one hundred miles away, and for those cases living in rural communities who need preventive and more moderate therapeutic service, there simply is none available, except where socially minded physicians are willing to add to their heavy charity load. The incidence of tuberculosis is simply appalling among the entire population. Likewise, syphilis and gonorrhea are exacting a terrific toll and creating a public problem for which no appreciable answer yet exists.

A surprisingly small number of serious antisocial problems

were uncovered. It is true, there were many cases in which behavior was a part of the problem, and indeed the immediate basis for referring the case. When allowance has been made for educational maladjustments, then the number that can be regarded as more tragically serious becomes much smaller.

The conclusion seems inescapable to the writer that while really valuable improvements can be made by certain alterations within the educational system, a much more fundamental change is necessary before anything like a satisfactory solution can be reached. Economic conditions are in general so bad that anything really vital means consideration of this as an essential part of the problem. Naturally this cannot be discussed in a report given over to more specific attackable conditions.

In closing, it should be stated that the spirit among the practitioners, social workers, educational field agents, and teaching staffs is excellent. In the face of economic, social, physical, and educational problems that would seem to an outsider overwhelming, they were keeping up an optimistic spirit and working steadily long hours, month in and month out.

ALBERT MOORE BARRETT

DR. ALBERT MOORE BARRETT, Director of the Michigan State Psychopathic Hospital and Head of the Department of Psychiatry at the University of Michigan, died suddenly on April 2, in his sixty-fourth year, following a heart attack.

Born in 1871, in Austin, Illinois, Dr. Barrett received his A.B. from the University of Iowa in 1893 and his medical degree from the same institution two years later. His identification with psychiatry came early, as he was appointed pathologist to the Independence (Iowa) State Hospital immediately after his graduation. Later he served as assistant physician at Worcester and, after a year's study at Heidelberg in 1901, entered upon the duties of pathologist at Danvers. Several years later, in 1905, he was in addition made assistant in neuropathology at Harvard.

In 1906, Dr. Barrett was called to organize the State Psychopathic Hospital at Ann Arbor. As the head of this institution, the first of its kind in America and a landmark in psychiatric progress, and as teacher of psychiatry at the University of Michigan, Dr. Barrett continued for thirty years, until his death. For many years a member of The National Committee for Mental Hygiene, he took an earnest and active interest in developments within this field.

Dr. Barrett was unquestionably one of the important figures of his generation in medicine. As teacher, scientist, organizer, and executive, he made a signal mark and leaves a valuable and significant impress upon thought and procedure in his specialty. Open-minded and imaginative, yet with a fundamental conservatism and restraint, his views were thoughtfully and pragmatically evolved, not born of mere impulse or enthusiasm.

His interests were broad and far-reaching, leading to active and helpful participation in the work of many professional societies and special groups. In the course of his long and fruitful career, he received many, and well merited,

honors. Thus, he was past president of the American Psychiatric Association, of the American Psychopathological Association, and of the Central Neuropsychiatric Association. Also, at the time of his death, Dr. Barrett was President of the American Neurological Association, and Salmon Lecturer for 1937.

Forceful, sanguine, and vital, with a shrewd sense of practical values and a sincerely progressive scientific spirit, imbued with a fine feeling for work and order, Dr. Barrett was a man of brilliant, sensitive, and inquiring mind, withal direct, simple, and unaffected. These qualities, with his broad culture and charm, warm humanness, and genial, whimsical humor, go far to explain his professional achievement as well as serving to endear him to a multitude of students, coworkers, and friends.

With Dr. Barrett's death an outstanding and colorful personality is lost to American psychiatry. The loss is the more significant in that he was one of that distinguished group of pioneers who, from the beginning of the century, did so much to advance and quicken psychiatry, and to establish it soundly as a true and functional aspect of medicine and an instrument of human welfare.

THEOPHILE RAPHAEL.

BOOK REVIEWS

TWENTIETH CENTURY PSYCHIATRY. By William A. White. New York: W. W. Norton and Company, 1936. 198 p.

This latest book by Dr. William A. White, composed of the three Thomas W. Salmon Memorial Lectures delivered in 1935, bears a fitting title. No one is better qualified to present this retrospective, analytical, and forward-looking contribution than the man who has been one of the outstanding leaders in psychiatric thought for more than forty years. The lectures are a scholarly and thoughtful presentation of the history, successes, and potentialities of Dr. Salmon's "Cinderella of Medicine."

The three lectures that make up the book are: (1) *Psychiatry as a Medical Specialty,* (2) *The Social Significance of Psychiatry,* and (3) *The General Implications of Psychiatric Thought.* There is a short preface and several splendid introductory paragraphs, presenting an historical sketch of psychiatric practice from a "therapy of negation to active psychotherapy." Under Dr. White's eyes the false trail of the tendency to classification gave way to a new approach more capable of capturing the imagination of the scientific mind.

In the first lecture, Dr. White reviews the contributions of the psychoanlytic and the mental-hygiene movements, discusses the biologic basis of personality structure, his energy concept, the influences of heredity and environment, and regression and compensation.

The organism-as-a-whole concept is illuminated by reference to the psychopathology of paresis and Parkinson's disease. Rules are set forth that may well be taken over by medical men in every special field, such as the following: "An organ or a function about which the important creative aspects of the personality have been nucleated and through which they have been expressed should always be protected with the greatest care and should never be sacrificed under any circumstances, if it can possibly be avoided, for the salvaging of an organ or a function of lesser significance." A second principle is: "No operation of election on an erogenous zone should be performed unless the patient is psychologically prepared."

With regard to psychoanalysis, Dr. White felt early in the century, as Freud did, somewhat apprehensive of its future in America, as it was received here with open arms and too uncritically. Criticism, in Dr. White's view, represents the difficulties that have to be overcome, and new movements like psychoanalysis need all the criticism they can get because they require the strength that comes only from surmounting obstacles. Dr. White believes that the outstanding goal

of our efforts, as represented by the psychoanalytic school, is "to build up slowly and painstakingly an anatomy and physiology of the psyche comparable in exactness of its outlines and complexity of its structure to the anatomy and physiology of the body." He feels that the criticisms of psychoanalysis have been aimed at the "content of what was disclosed by the psychoanalytic method and not at the processes or the mechanisms or the form of the neuroses or psychoses." He makes this sound critical statement: "It must be recognized regarding psychoanalysis that despite apparent opinions of some of its advocates it does not offer a methodology which at the present time would be thought of as replacing all others in the field of psychopathology. We must be prepared to follow the course of scientific unfoldment wherever it may lead and we must consider psychoanalysis as a body of expanding and developing knowledge. One who has lived through in experience its relation to psychiatry could hardly fail to appreciate its invaluable contributions and be convinced of its future possibilities."

In the second chapter, Dr. White outlines the magnitude of the mental-health problem, cites statistics, and discusses the mental-hygiene movement as a force for social betterment. Psychiatric concepts are carried into the fields of education, industry, and criminology. The chapter represents a plea for sound, understanding, and humane approaches to these great social needs and suggests also ways in which present-day psychiatric insight can be of invaluable assistance.

The third chapter—*General Implications of Psychiatric Thought*—elaborates the parallelism between the standpoints of the psychiatrist and the physicist. Dr. White's sweeping and dynamic presentation of changes in our ways of thinking brought about by or contributed to by the psychiatric point of view is of great value. Determinism and free will are discussed in the light of psychiatric experience. The relation of the psychotic to the world of reality, the biologist's contributions to the understanding of behavior, instincts, anxiety, the energy concept, and compensation are dealt with in a scholarly fashion. Anxiety is discussed from the point of view of the light that it sheds on the way in which the evolutionary mechanisms operate at the psychological level. Dr. White states, "At any given time when either the instinctual forces are strengthened or the repressing and sublimating forces are weakened, anxiety may develop, and in these circumstances one of the solutions that presents to the patient a means of escaping the torment of this mental state is to do those things which will reconstitute the supremacy of sublimation and repression, or, in other words, to move in a direction away from the instinctual forces and towards those processes which make

for development in the direction conceded to be evolutionary. If I am correct in this assumption, then we may assume, I believe, that anxiety is one, at least, of the outstanding forces which drive man along the path of development and civilization. I should dislike to think that it was the only force, for if that were so then all of men's virtues could be explained by fear. I cannot but believe that while anxiety may be a compelling factor, it should be considered, as it were, as pushing from behind, whereas other forces which attract from before, in accordance with the ambivalence of all manifestations of energy, need to be fully taken into account."

There is in this contribution, as in all of Dr. White's writings, a deep understanding, not only of the field of psychiatry itself, but of its correct evaluation in its relationships to science and philosophy. It is a book for psychiatrists, for medical practitioners and educators—in fact, for all workers in the field of human relationships. It will be of special value to the intelligent layman eager to orient himself in a highly controversial field and willing to stumble over some unfamiliar words. A vast range of material is presented with a depth of perspective that will bring broader vision to the students and practitioners of psychiatry and its branches. It offers the benefits of Dr. White's experience and thought to those of us who are too close upon our own growing concepts or too young in experience to be able to crystallize our own philosophy.

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HEALTH AND HUMAN PROGRESS. By René Sand. Translated from the author's revised French text by C. F. Marshall. New York: The Macmillan Company, 1936. 260 p.

This volume, consisting of 260 pages, a complete bibliography, and an index, represents a broad grasp of the relationship of medicine to social and human progress. The preface is by Monsieur Édouard Herriot.

Chapter 1 gives a brief historical account of the development of sociological medicine throughout the world. Naturally it is not practicable in a volume of this size to go into details, but the author, with bold strokes, outlines the picture of the advent and growth of sociological medicine. The bibliography for this chapter is worth review for any one interested in the history of this movement.

The second chapter deals with the sources of sociological medicine; the third with a discussion of the various social classes, the author pointing out that general sociology "studies the origin, structure, function, and evolution of communities; it seeks to grasp the essentials of social relationships, forces, and institutions." Here he dis-

cusses such factors as density of population, distribution of population, the active, the non-active, the unemployed, and the aged.

Chapter 4 is devoted to the subject of "the balance-sheet of sickness and death." Herein are discussed such specific problems as pestilential diseases (including such infections as tuberculosis and syphilis), maternal mortality, pre-natal and infant mortality, cancer, general diseases, chronic affections of the circulatory system, and alcoholism. Chapter 5 is devoted to physical and mental inequalities between the various social classes and occupational groups. Chapter 6 points out the inequalities of the social classes as regards death and sickness.

Heredity and environment are discussed in Chapter 7, and hereditary factors are further amplified in Chapter 8. Occupational, domestic, economic, sanitary, and educational factors are covered in the next succeeding five chapters, while human economics is discussed in the last or fourteenth chapter of the book.

The book may be read with profit by those who are interested in the broader aspects of mental hygiene, with special reference to the conservation or the promotion of good mental health. The sociological problems discussed in the book are sometimes directly or indirectly related to the problems of conserving the physical and mental health of a population. Social morbidity and mortality, heredity, occupational hazards, child and women labor, night work, home work, overwork, and other occupational factors, are related, directly or indirectly, to the conservation of mental health.

Such social problems as population density and movement, geographical and age distribution, physical and mental inequalities, sickness and deaths, occupational groups, and so forth, all carry implications for the field of mental-health conservation. A more intimate knowledge of the method and technique of sociology and its practical application may have significant contributions to make that indirectly will serve mental hygiene in its broader applications. All those interested in the prevention of mental illness and the promotion of positive mental health will profit by reading *Health and Human Progress.*

WALTER L. TREADWAY.

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THE EVOLUTION OF MODERN PSYCHOLOGY. By Richard Müller-Freienfels. Translated from the German by W. Béran Wolfe. New Haven: Yale University Press, 1935. 513 p.

The Evolution of Modern Psychology is the work of a German author little known in this country. Müller-Freienfels is not prima-

rily an experimental psychologist. In addition to the more orthodox psychological problems, his publications deal with the psychology of religion, of art, of German culture, and with the "philosophy of life." His own system is expounded in a volume entitled *The Principles of Vital Psychology*. The vitalism-materialism controversy is apparently a live issue to him. Unlike the majority of psychologists with whom the American reading public is familiar, he concerns himself largely with philosophical and speculative questions. As one might expect, the direction of his interests is reflected in his presentation of the development and present status of psychology.

It is a curious shock, on first reading the book, to find the word "soul" appearing in connection with almost every problem. The author, however, is apparently himself aware of this unusual (for a psychologist) terminology, for he states that "the problem [of the soul] suffers little change should we supplant the word 'soul' with 'self' or 'subject' or 'personality'." In other words, the author is aware of the danger of throwing out the baby with the bath, of losing track of the broader problems of personality in our endeavor to be strictly "scientific," as so many American psychologists have done. But, in the light of the above quotation, the book is disappointing. It is, for all its frequent verbal references to the problems of the "soul," curiously academic. It is of far greater interest to the college professor in need of a competent history of psychology than to the general reader who wishes to catch the general tenor of the psychology of 1935.

Another problem that haunts the book to a disconcerting extent is that of the analysis of the contents of consciousness into elements. There was a time—roughly before 1910, and especially in Germany, where experimental psychology got its start—when this was the central problem of psychology. Consciousness psychology has been pushed to its logical—and practically suicidal—conclusion by Wundt and his followers in Germany and, more recently, in this country by Titchener and an ever-decreasing group of disciples. Psychologists in general are turning to more fruitful problems and methods. It comes as rather a surprise, therefore, to find the problem figuring so prominently in a current book. Müller-Freienfels constantly justifies, and practically apologizes for, the fact that this or that school or movement—for example, the Gestalt school or psychoanalysis—does not concern itself with the analysis of consciousness.

The book is divided into six parts: (1) *How Psychology Became Conscious of Consciousness;* (2) *Physiopsychology and Psychophysiology;* (3) *The Psychology of Action and Conduct* (including behaviorism, functionalism, psycho-vitalism, and German psychomotor psychology); (4) *Psychology with "Soul";* (5) *Psychology of the*

Unconscious; and (6) *Psychology of the Superindividual Life.* This last part deals with some of the problems generally included under social psychology, broadly interpreted.

Characteristically, the book closes with a section entitled *Is There a Soul?* in which the author concludes that "the denial of the psyche which was characteristic of the gross materialism of recent years can to-day find very few advocates . . . Perhaps the question of the soul can be solved only in conjunction with the solution of the problem of the nature of the world as a whole."

There follows an appendix on psychic research and allied phenomena.

A long and exhaustive biblography, reflecting the author's thoroughness and erudition, completes the book.

HANNA F. FATERSON.

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GESTALT PSYCHOLOGY; A SURVEY OF FACTS AND PRINCIPLES. By George W. Hartmann. New York: The Ronald Press, 1935. 325 p.

This is a very interesting and useful volume. It represents a careful, painstaking effort to summarize the work to date of Gestalt leaders, to show how the movement originated, to present the significant experimental and logical evidence that has accrued, and to evaluate the present position and the progress made. The author has made available, in convenient form, the substance of many publications that would ordinarily be beyond the purview of the student not thoroughly grounded in German language and thought. He has selected his material very carefully, and has presented his story sympathetically, clearly, and—in the main—non-critically.

The book is divided into five parts. Part I deals with the antecedents and development of the Gestalt doctrine, and is necessarily brief and systematically inadequate. Part II is a theoretical section, attempting to draw together the physical, physiological, and philosophical bases of the Gestalt theory, and indicating the relationship of the Berlin school to that of Krueger and to the work of Sander, Katz, and others.

The main section, Part III, presents an excellent selection of experimental evidence, and happily avoids too much emphasis on visual perception—whence has often come a less dynamic interpretation of the theory. The systematic investigation of all sensory phenomena, of memory processes, of learning, thinking, and reasoning, of action, emotion, and will, is discussed sufficiently to show the significance of the Gestalt method, and to indicate fairly clearly the results so far achieved.

Part IV suggests practical implications of the theory in the realms of mental pathology, industry, and education. Its best feature is again the citation of experimental accomplishments. With no intention of playing the rôle of evangelist, the author has naturally avoided too enthusiastic and detailed an indication of the meaning of Gestalt theory in these practical fields, with the result that the value of this section to the student will depend on the vision of the instructor.

Part V discusses the bare bones of a few outstanding criticisms, such as those of Muller, Rignano, and Petermann, and concludes with an extremely short statement as to the present status of the school. An interesting, but not very valuable, table of significant dates is appended, together with a glossary of the more important terms encountered in Gestalt literature.

The author has attempted a difficult task, and has performed it directly, honestly, and skilfully. There is no attempt at propaganda, and the entire presentation is concise yet clear. Such weaknesses as are displayed seem to derive from the almost impossible nature of the task. Thus, it is hardly adequate to present the story of Gestalt as a movement without a good deal of historical background that would be beyond the scope of a book such as this. Similarly the critical section demands, on the part of the reader, an equally sensitive knowledge of the past developments of other great psychological movements. Wise teaching, however, can take care of these aspects, so that for mature classroom discussion the book should prove to be extremely valuable.

W. Line.

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An Introduction to Educational Psychology. By Coleman R. Griffith. New York: Farrar and Rinehart, 1935. 754 p.

This volume is offered with the frank recognition that educational psychology at its best may still leave the teacher in the midst of a complex teaching situation fully conscious of the ineffectiveness of experiment and theory which focus on mere segments of his problem—unless, indeed, it has the opposite effect of leaving him so enamored of the contribution to a troublesome part that his inclination is to ignore the totality. Professor Griffith has undertaken, therefore, to steer a course between "a systematic arrangement of facts," with "too much space devoted to laboratory research and to the formal presentation of facts independently of their practical and social values," and the overemphasis of "instances drawn from the daily life of teachers in the schoolroom." His purpose has been to build a "coherent view of the one concept that is essential to the teacher—viz., the whole pattern of growth as it is promoted and guided by

formal and informal schooling." And he has, it should be remarked, succeeded admirably, in a volume overlong, in making concrete the purposes thus expressed in his prefatory statement.

It is perhaps fair, too, to suggest another course that Professor Griffith set out to travel, one that kept away from theoretical conflict, at least until after all of the evidence was in. Thus, the final chapter deals explicitly with what must continuously appear by implication throughout the rest of the volume—conflicting points of view in psychology. True enough, the author's adherence to the genetic view is evident at every turn as the presentation moves forward, and the emphasis thus placed, aiding as it does the teacher to view the student as a being actively within the stream of his own history, is both hopeful and educationally sound. The shaping up of conflicting views at the outset, however, for the purpose of keeping the educational implications of each theory to the fore as facts come up for review and interpretation, would seem to this reviewer to hold more promise for the full effectiveness of such a volume in the hands of the teacher, giving it more significance for actual practice and for its reconstruction. The existence of educational psychologies is full evidence of the existence of variety in educational purposes, and these relationships need to be smoked out as the psychological and educational are under scrutiny.

But this is a matter of emphasis. The author has in no sense overlooked the problem. Yet, had the conflicts been placed in developmental contrast throughout, the warning in the final chapter—"the student should not take too seriously the use which has been made of the methods of behaviorism" (p. 733)—would not be needed. Since the author insists that "the whole pattern of conduct displays features or properties which distinguish human beings from all other classes or objects" (p. 733), the student should indeed not take the methods of behaviorism too seriously. They are not appropriate, except as they present a contrasting view of educational psychology at work.

The book is divided into three parts: I, *Methods of Promoting Growth;* II, *Original Nature and Learning;* III, *Conceptual and Methodological Tools of Education.* In treatment Professor Griffith has managed, with an unusual degree of success, to build the supports of experimentation into a smoothly running story. A boring recital of facts never results. The intelligent, and plentiful, use of footnotes, together with the organized and directed reading suggestions that accompany each chapter, carry the full flavor of scholarship without permitting it to intrude upon the quality of readableness. This in itself is an achievement of real merit in a book in this field.

The significance of the volume for education is nowhere better

shown than in Chapter 7, in which the author endeavors "to find out what the process of solving problems consists of and how this process may be aided by teaching methods" (p. 222). The former purpose is better served than the latter, as it happens, but education itself is well served by the recognition that a parade of memorized facts is no final mark of educational attainment. The teacher will find the discussion of the various uses of the term "thinking" useful in analyzing current educational practice; he will see in the discussion of the nature of problem-solving the imperative that the school give the student *problems to solve* and not simply problems previously solved; and he will find in the presentation of bases of problem-solving and sources of training fruitful suggestions for the building of teaching situations that will give the student opportunity to tackle problems and facilitate the development of a technique for solving them. Professor Griffith shows his understanding of the teaching side of problem-solving when he says, concerning our failure to lead students to independence in discovering relationships, "Instead of preparing situations so that relationships will easily emerge, teachers are inclined to furnish not only the situations, but all of the relationships as well" (p. 247). That understanding is further indicated as he lists the reasons for this inclination:

> "They do this, in part, because their classes are so large that they cannot spend the time that is necessary to create a problem-exciting situation; in part, because they have been over-influenced by the laws of learning which have seemed to simplify so greatly the complexities of teaching procedure; in part, because it has been supposed that the growth pattern can be brought to completion through the use of learning situations alone; in part, because most teachers, especially in the elementary grades and in the high schools, have to carry a very heavy teaching load; and, in part, because there is really a dearth of active intellectual interest among teachers themselves" (p. 247).

This chapter, incidentally, is a crucial one in the volume. It is a constant source of reference in the earlier and later stages of the discussion, and the emphasis laid upon the play of intelligence in the pattern of growth of the individual must be grasped if the point of view of the author is to be finally understood. It would appear, however, that in pressing properly for a distinction between "logic" and "thinking," Professor Griffith has permitted his differentiation to lead him to a limited view of problem-solving. He views logic as "something that we do to a discovery in order to make the discovery convincing to some one else," not as "a description of the process of discovery itself" (p. 225). What he does next, however, as he attempts to view the individual as a psychological unit concerned with the solving of a problem and not with a demonstration of logic, is to

place such emphasis upon *discovery,* upon insight, that he underemphasizes the necessity of the testing *by the individual* of *his* discovery.

The need for this test is not removed by Professor Griffith's distinction. Until it is made, thinking has not really taken place, nor has the problem been solved. The author does not quite suggest this need when he states that "the real essence of problem-solving is to be found in the insight or the hunch rather than in the methods that are used to prove the essential correctness of an insight or a hunch to some other person" (p. 240). The very thing on which education needs to focus—methods of testing hunches or insights—is thus neglected. So too, then, will be the desire.

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Autobiography. By Sigmund Freud. English translation by James Strachey. New York: W. W. Norton and Company, 1935. 153 p.

The present work appeared originally in 1925 in a German publication which brought together a collection of autobiographical studies by leaders of the medical profession. An English translation by James Strachey was published in American in 1927. Unfortunately this was brought out in the same volume with another essay by Freud, *The Problem of Lay Analysis,* which gave the title to the book and thereby obscured the more important communication. This new edition makes the autobiography available for the first time in English as an independent work. The original translation has received minor revisions and is supplemented by a number of footnotes by Freud and a postscript chapter in which he covers his life and work over the past ten years.

This book, like all of the author's writings, is characterized by frankness, self-confidence, tolerance, and extraordinary powers of condensation. The life of Freud and the history of psychoanalysis are so closely intertwined that a discussion of either subject must include the other. In this presentation the personal autobiographical material is made a simple framework for the story of psychoanalysis, both as to internal growth and external history. In orderly sequence and with rare clarity, every phase and ramification of this story is developed. The result in one small volume is an epitomized encyclopedia of psychoanalysis in the setting of a rich and revealing human document.

To those already familiar with this autobiographical essay, the brief postscript of eight pages will be of special interest. At the time of writing the original sketch, Freud was suffering from a serious phys-

ical disorder, and he now admits the conviction that he had not long to live. Happily, this expectation proved unwarranted, and he has been able to continue his analytic work and writing without cessation. He points out a significant change during later years in the direction of his special interests, in what he refers to as "a stage of regressive development." By this he means that he has been led to neglect the purely clinical features of psychoanalysis in favor of the cultural problems of mankind, which were his original concern, and to which he has returned "after a lifelong detour through natural science, medicine, and psychotherapy." The author views these cultural problems as simply the repetition on a wider stage of those same processes which are operative in the individual and which psychoanalysis has done so much to reveal through exploration of the unconscious mind. His more recent books, *The Future of an Illusion* (1927) and *Civilization and Its Discontents* (1930), reflect this transfer of interest in psychology and psychopathology from the individual to the social.

Freud's earlier work was so carefully done that he finds little in it to modify. Exceptions include some incompleteness in the concept of female sexuality, a revision of the problem of anxiety, and (welcome to the spiritually minded) some qualification of the essentially negative values that were previously given to religion.

The reviewer cannot refrain from reference to an explosive topic in the book which belongs to literary circles rather than to psychoanalysis. In commenting on the application of psychoanalytic knowledge to the drama, reference is made to the now familiar interpretation of *Hamlet* as a disguised version of the Œdipus problem, and it is pointed out that this play was written shortly after the death of Shakespeare's father. The following footnote is appended (p. 130):

> "This is a construction which I should like expressly to withdraw. I no longer believe that William Shakespeare, the actor from Stratford, was the author of the works that have been ascribed to him. Since reading *Shakespeare Identified*, by T. J. Looney, I am almost convinced that the assumed name conceals the personality of Edward De Vere, Earl of Oxford."

There is an interesting discussion at the end of the last chapter concerning the present status of psychoanalysis throughout the world and in the closing words the present situation is summed up as follows: "The whole impression is a satisfactory one of serious scientific work, carried out at a high level."

MARTIN W. PECK.

Boston, Massachusetts.

FOR STUTTERERS. By Smiley Blanton, M.D. and Margaret Blanton. New York: D. Appleton-Century Company, 1936. 191 p.

As I reached the last page of this moderate-sized book, I had the feeling that I had just finished reading a large and comprehensive work. This feeling was undoubtedly due to the fact that the authors have succeeded in condensing in this small volume an enormous amount of very useful and valuable material relating not only to stuttering, but to all the phases, normal as well as abnormal, of human speech.

Dr. J. Ramsay Hunt, in his appreciative introduction to this work, justly states that stuttering is a psychoneurotic disturbance, a view shared by all serious observers of this phenomenon, particularly by the followers of the Freudian discipline. For speech disturbances cannot possibly be detached from those mental and emotional difficulties which assail the individual in early life. It is only rarely that one finds stuttering that has made its appearance in adult life; like any other psychoneurotic symptom, stuttering is a flourishing manifestation emanating from abnormal infantile experiences. With this in mind, the authors present an excellent outline of all the mental processes that touch upon and appertain to the normal and abnormal phases of speech.

The first nine chapters are devoted to a general outline of the psychic apparatus, in which we find very clear and informative descriptions of the various levels of the mind, such as the growth of conscience, anxiety, and the emotional patterns of forgetting, projection, and rationalization.

In the next ten chapters, which deal directly with all phases of stuttering, one finds the theories, causes, and treatment of stuttering reported in the abundant literature on the subject. Because of their wide experiences, not only with the subject of speech, but in psychiatry and psychoanalysis, the authors discuss this difficult problem in a very sympathetic and thorough manner. One feels that they are perfectly at home in this strange field and they impart their information to the reader concisely and clearly. Nothing is omitted.

The Blantons are deeply impressed by psychonanalysis, and while the Freudian mechanisms are in evidence in both the theoretical and the practical part of their work, they, nevertheless, give due credit to the theories and methods of other schools. Thus, they fully discuss such measures as retraining of the hand, relaxation, reading aloud, phonetics or sound drill, operation, and suggestion, which other investigators utilize in the treatment of stuttering. For this malady has been treated in many ways from the very beginning of medical practice. Some of the methods thus used are based on sound principle, while others represent nothing but pure quackery. It is

gratifying to state that the authors have properly evaluated these theories and procedures, and their remarks on quacks are very pertinent. The authors also discuss the stutterer's chances for recovery, and from my long experience with such cases I was impressed by their candidness. As the environment is of great importance in the production and treatment of neurotic disturbances, the authors very illuminatingly discuss what the parents can do, what the teacher can do, what the public can do, and what the stutterer can do.

Altogether the authors have produced a very sound and informative work, which can be read with benefit not only by those who devote themselves to the study and treatment of speech disturbances, but also by physicians, psychologists, teachers, and laymen.

A. A. Brill.

New York City.

Education of the Slow-Learning Child. By C. P. Ingram. Yonkers, New York: World Book Company, 1935. 419 p.

When the White House Conference Report on Special Education appeared in 1931, many educators and specialists were surprised to learn that only 60,000 of (an estimated) 450,000 mentally retarded children were enrolled in special classes. Moreover, several studies showed that the instructional methods and materials of special classes in vogue at that time precluded (in typical instances) the children's maximum development—particularly in social growth and understanding. One reason for this condition was to be found in the books and guides for teachers of the mentally retarded. Many of the books stressed special and narrow objectives, drill exercises, or very detailed therapy far removed from the practical needs and dominant interests of these children. Furthermore, the "scientific" treatment of these children made them stand apart as a special group—and the lamentable array of specific "training" devices was equaled in absurdity only by the appalling and depressing photographs of mental defectives in the books upon the dull and the feebleminded.

It is refreshing indeed to find in Miss Ingram's book a straightforward, practical account of the nature and needs of these school children—an account which recognizes that "the principles underlying the education of all children are . . . fundamentally the same." But of course the slow child needs numerous adaptations of materials and methods of instruction; hence the major portion of the book is devoted to discussions of these in relation to the characteristics and capacities of this type of child. It is recognized, moreover, that an effective educational program must make allowance for the rate of mental development of these children, which is—and will continue to be—slow. Content and method, therefore, should be developed

about and adjusted to the resultant maturation levels of the individuals as well as of the groups. Particularly important is it, however, that the curriculum be devised in such a way that a natural coalition will be effected between immediate life problems and school experience. Moreover, the children should sense the relevancy of the educational goals to their individual problems and interests. Successful attainment, thus realized, provides the sole basis for the effective and continuous adjustment and growth of retarded school children.

The author faces frankly the problem of identification of the mentally retarded. Because of immature physical development, emotional instability, and other factors, some children with I.Q.'s above 70 or 75 require for their optimal growth the educational program planned for the mentally retarded. The author, however, is concerned in general with the needs of children whose I.Q.'s range from 50 to 75 (about 2 per cent of school children).

Chapter 2 contains an excellent discussion of the physical, mental, educational, and social characteristics of this group. The ages or levels of development (Bird Baldwin's classification) are examined; finally three general levels are selected, and a developmental chart clearly depicting and conveniently summarizing the growth of mentally retarded children is appended. In this presentation the physical, social, and mental traits of retarded children are summarized in the following age groups: 8, 9, and 10; 11 and 12; and 13, 14, and 15 years. Since this is only a brief, general chart, three case studies are included to illustrate the specific developmental levels. The reviewer believes that this section may be read profitably by all teachers, since every teacher must attempt to understand and guide the growth of many slow-learning children. A better understanding of children's individual and group needs should result from careful study of this provocative treatment. In addition, this should lead to a more fortunate pupil-teacher relationship.

In Chapter 3, educational principles are set forth. Guiding the discussion is a recognition of the significance of the development of initiative, self-confidence, and self-direction through school situations which permit children to sense and to achieve goals that are in harmony with their interests, abilities, and life needs. The educational (and life) objectives that follow are logical outcomes of this point of view. The discussion of the problems of class organization is consistent also with the principles and objectives. Hence, the special class becomes an educational laboratory "for observing, studying, interpreting, and guiding the development, behavior, and physical well-being of children." Specific methods are set forth; and illustrative activity units (fully described) for children of various levels make this book a very practical guide for teachers who desire to

initiate and carry to completion projects along similar lines. The book is admirable in being practical and yet not a pedantic rule-of-thumb set of directions and simple drill devices. The inclusion of lists of books appropriate for children of various ages and a well-chosen bibliography for teachers are commendable features of the sections of this book that deal with the retarded child.

Part III, consisting fortunately of *one* short chapter, deals with the border-line and the dull-normal child. It appears to the reviewer to have no logical place in this otherwise excellent book. The author, it seems, realized this, too, for the style is stilted and uninspired, the suggestions pedantic. The reader who could profit from reading the other sections of the book would sense their implications for dull-normal children.

The reviewer believes, however, that Miss Ingram has prepared the most practical, psychologically and philosophically sound book in the field of special education. It is his hope that the book will be read widely, and its suggestions encompassed in modified curricula for the slow-learning child.

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A COMMON FAITH. By John Dewey. New Haven: Yale University Press, 1934. 87 p.

A fundamental need of mankind, one that mental hygiene has recognized from its beginnings, is for harmony of personality, absence of disintegrating conflict—in other words, the need for integration. Dr. Dewey seems to recognize this need and the fact that religion has often proved to be an integrating force in human lives when, in this book, *A Common Faith,* he seeks to bring back, to persons who have lost their faith in the supernatural, religious sentiments and motives that may supply a unifying force no longer available through more traditional "religions." He uses in a convincing way the argument that there have been many religions and that in the majority of them elements from man's lower nature and from primitive customs and superstitions hold an important place. On the other hand, he says, there are "elements and outlooks that may be called religious" which might well be emancipated from religion, with its crystallization of primitive beliefs and inflexible dogma, "encumbrances that now smother or limit it." Thus emancipated, these "elements and outlooks" may come to the surface as attitudes which will prove the harmonizing forces that all of us need.

"Religious," Dr. Dewey states, "denotes nothing in the way of a specifiable entity, either institutional or as a system of beliefs. It does not denote anything to which one can specifically point as

one can point to this and that historic religion or existing church. . . . It denotes attitudes that can be taken toward every object and every proposed end or ideal."

These religious attitudes, he believes, can operate as religion has operated when it has been a truly constructive force in human lives. He describes the result of a dynamic religion in a way that all mental-hygienists must recognize as valid for the integration of personality: it brings about "the existence of some complex of conditions that have operated to effect an adjustment in life, an orientation, that brings with it a sense of security and peace." But he separates this outcome from any necessary causation in religion when he states that "the stable outcome is so invaluable that the cause to which it is referred is usually nothing but a reduplication of the thing that has occurred, plus some name that has acquired a deeply emotional quality." The *religious* quality in this experience, he affirms, is its effect—"the better adjustment in life and its conditions"—and not the way it was brought about. "The way in which the experience operated, its function, determines its religious value." Therefore, anything that can bring about harmony and an orientation to life on its highest levels is religious.

As to belief in the supernatural, Dewey assumes from the start that this is necessarily an escape, the opiate which it is now so widely designated by people who cannot accept traditional religion. "Dependence upon an external power is the counterpart of surrender of human endeavor." And on the other hand, "there is at least enough impulse toward justice, kindliness, and order so that if it were mobilized for action, not expecting abrupt and complete transformation to occur, the disorder, cruelty, and oppression that exist would be reduced."

This is not the place to discuss the philosophy of Dewey's thesis or to enter upon a religious argument. What are the implications for mental hygiene in the author's contention? It seems to the reviewer that Dr. Dewey has made two assumptions that are possibly not in accord with conditions. In the first place, he seems to be discussing an inflexible religion of creeds and dogma as if there were no other. Many religionists, in whose lives religion acts as a challenge and not as an escape, still hold to their faith in a supernatural being, very different, to be sure, from the old man with a white beard, ruling the world from his throne beyond the sky, but none the less a source of power and of sacrificing love. In the second place, he seems to have in mind a small group of people exceptionally well endowed, both intellectually and emotionally, whose need for any God differs as much from the need of the ordinary run of humanity as the need of Peter and Paul differed from that

of Moses and Aaron. One of the most fascinating phases of Bible study is tracing the gradual development of the idea of God from the primitive local deity of Abraham, jealous of his position with his chosen followers and relentless in punishing their enemies as well as their own derelictions, to the God of love and mercy of the New Testament. Dr. Dewey evidently holds that a further development will eradicate the idea of God altogether and substitute what he calls at one point "ideal ends." One cannot refrain from quoting his telling description of such ends: "There are values, goods, actually realized upon a natural basis—the goods of human association, of art and knowledge. The idealizing imagination seizes upon the most precious things found in the climacteric moments of experience and projects them. We need no external criterion and guarantee for their goodness. They are had, they exist as good, and out of them we frame our ideal ends." These ends, he goes on to say, can best be realized through the "coöperative and communicative operations of human beings living together"; they "assume concrete form in our understanding of our relations to one another and the values contained in these relations."

The difficulty with all this is that humanity—with the possible exception of the small group represented by Dr. Dewey and others of his intellectual power and self-mastery—is not yet ready to turn to themselves for the values an "idealizing imagination" may give to life in all its phases. We are children in this overpowering universe. Our increasing knowledge of its overpowering nature, our control over some of its elements, only serves to emphasize our lack of knowledge and control in relation to the greater part. Where do children turn for clues to the bewildering adult world in which they find themselves? Certainly not to themselves. It is not yet time, so far as mental hygiene is concerned, to direct confused and frightened personalities to look wholly to themselves for clues to a way through the confusion and an antidote to the fear.

On the other hand, Dr. Dewey has raised to a high level of value the power for human good that exists in the common happenings of life. Within human relationships lie possibilities for integration. Unifying forces exist just because we live together in communities where opportunities for coöperation abound. In his own words, "unification of the self . . . cannot be attained in terms of itself. The self is always directed toward something beyond itself, and so its own unification depends upon the idea of the integration of the shifting scenes of the world into that imaginative totality we call the Universe," and some of us call *God*.

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WHY WE FEEL THAT WAY; AN ANALYSIS OF THE HUMAN EMOTIONS. By Augustus W. Trettien. Boston: The Stratford Company, 1935. 452 p.

According to the author, a quarter of a century has elapsed since he was inspired by Dr. G. Stanley Hall to investigate "emotions in man." This probably explains why, out of forty-two items in his bibliography, nine belong to the period of 1915 or earlier, while only five were published in the period 1930 to 1933.

The general level of the book is indicated by the fact that in three and one-half pages of the glossary there are more than ten inaccuracies, varying from such misspelling as "nurone" to terms like "psychotic-emotional instability." In content one finds more attention paid to the writings of Berman than to all of those by Freud, Jung, and Adler; in fact, the two latter are not mentioned. The attitude toward psychoanalytic doctrine as a whole is well illustrated by the fact that the term psychoanalysis does not appear in the index, although on page 352, the author indicates his belief that "the psycho-analytical method, case history, habits and ideals, together with attitudes, still add much to the laboratory methods that may aid, but they are not of sufficient reliability upon which to establish a scientific fact." A two-page chapter is devoted to the training of the emotions. Crile, Dorsey, Darwin, and Cannon serve as the background of much of the scientific data, which is embroidered with Rousseau, Richter, and Huxley, not to mention Emerson and General Sherman.

There is ample evidence of carelessness in typography, but this is less significant than the inadequacy of the presentation of the theme, which falls far below present-day knowledge. Even admitting the validity of the author's measure of success—"Active-Mindedness, Open-Mindedness, and Kindliness"—one would not learn from this volume the nature, the development, and the utilization of the emotions for the attainment of such success. Unfortunately this book is written for the defenseless layman, who may not recognize that it possesses little scientific substance or authority.

New York City. IRA S. WILE.

C. P. SCOTT OF THE MANCHESTER GUARDIAN. By J. L. Hammond. New York: Harcourt, Brace, and Company, 1934. 365 p.

Mr. Hammond's book reveals clearly the reasons that made C. P. Scott one of the dominating personalities of his time. Those who know *The Manchester Guardian* only as an extraordinarily honest and reliable paper now realize that its steadfast policy was due to the integrity of the man who changed it from a small provincial

sheet into one of the most intelligent organs of opinion in the civilized world. When Scott assumed the editorship in 1872, the paper had only a local influence; when he retired in 1930, it had on more than one occasion shaped national policies.

The history of this transformation is an enlightening study of the forces that mold institutions and the motives that shape human behavior. Scott's life was centered in his work, and his paper reflected the quality of his mind, his high conception of the duties of an editor, and his courage in championing minority causes. His attitude during the Boer War, for example, was so unpopular that he was forced to have police protection for both his home and his office, but his course never wavered and ultimately his point of view triumphed. *The Manchester Guardian* became a moral force because, as Mr. Hammond points out, it was "a paper which was guided, whether it went right or wrong, whether it praised or blamed, by a large view and not a small view, by a generous and not a narrow spirit, by the desire to treat truth as the first need of good politics. And as self-respect and independence in the press of every country were in danger from vested interests of one kind or another, *The Manchester Guardian* was valued for a quality that men prized more as they missed it more."

There are many other passages in the book that would well repay further attention. But we will restrict this brief review to one point of great concern to the mental-hygienist—the secret of Scott's serenity in times of crisis. His concept of duty was so direct, simple, and reassuring that his soul was not torn by useless conflicts and vain regrets. When he had any momentous decision to make, he would first assemble all the pertinent facts, weigh them carefully and dispassionately, and then decide upon a course of action. To a friend who spoke about worrying for days over a decision and then, after it had been made, being perturbed as to its wisdom, Scott replied: "Never do that. It is a waste of energy, and interferes with clear judgment. When I am forced to make a difficult decision, I think it over quietly—weigh up all the facts, consider the rights and wrongs of the case, and come to a decision. I never worry afterwards about the difficulties, because when, after a considered judgment, I have come to a decision, I allow nothing to alter it, and that is the end." It is unfortunate that this book, which is extremely well written, remains "caviar to the general," for it deserves to be read by every one interested in the study of personality.

BESSIE BUNZEL.

Metropolitan Life Insurance Company, New York City.

THE QUEST FOR CORVO. By A. J. A. Symons. New York: The Macmillan Company, 1934. 293 p.

This is a study of an abnormal personality and as such it is of interest to the psychiatrist. The author starts off so brilliantly that the reader has every right to expect a penetrating analysis of a genius whose unfortunate temperament obscured great native ability and resulted in obliterating his genuine capacity as a writer. The synopsis of Rolfe's *Hadrian the Seventh* in the first chapter of Symons' book shows the striking power and originality of the man and is a most interesting narrative; but nothing that follows in *The Quest for Corvo* is as absorbing.

Symons' "experiment in biography"—as the subtitle of his book reads—concerns the checkered career of Frederick William Rolfe, the eldest son of a respectable middle-class Protestant family who was a misfit from his earliest youth. He left school at the age of fifteen, broke away from home, and became a tutor in a well-known school, a position from which he had to retire because of his conversion to Catholicism. He then entered a seminary to prepare for the Roman Catholic priesthood, but was expelled after a few months. He never recovered from the psychological trauma of this expulsion; the sense of injustice and persecution it engendered embittered the rest of his life and intensified his paranoid trends. His deep distrust of all those with whom he had dealings and his abuse of those who sought to befriend him were his answer to inner feelings of inadequacy and frustration. Rolfe was about thirty years old when he was forced to leave Scot's College in Rome, owing, as his superiors thought, to "his lack of vocation." About this time he became the protégé of an elderly Englishwoman (also a convert to Catholicism), the Duchess of Cesarini-Sporza, who gave him, he claimed, some estates, carrying with them a baronial title. At all events he assumed the name Baron Corvo. A few years later the Duchess refused to continue his allowance and from that time on he lived from hand to mouth, for the most part under conditions of extreme poverty and degradation, until his death in Italy at the early age of fifty-three.

Mr. Symons draws the picture of a sensitive artist, a writer of no mean attainments, a painter of talent, a musician of considerable skill, a conversationalist of charm, and a scholar of parts—in short, a man who could have gone far and accomplished much under more auspicious circumstances, but one whose wings were clipped by the violence of his temper, his inability to adjust to people, his megalomania and arrogance. In addition he was a sexual pervert, a seducer of young boys; and the biographer hints at even darker

adventures, but does not specify clearly what they were. Psychiatrists, if they had been given fuller information about these episodes, could better have drawn inferences concerning the distortion of personality that developed as a result of Rolfe's homosexuality. As a student of behavior, the general reader, too, would have liked greater vividness in the description of this self-tortured soul and fewer veiled allusions. In fact, the reviewer's main criticism of the book is its shadowy vagueness; its lack of clear-cut outlines gives the entire portrait an atmosphere of unreality. As a consequence, we seem to be dealing with a creation of the author's fancy. This lack of vitality in the characterization is a serious flaw in a psychological study. Great writers make imaginary characters live, and incidentally, in so doing, they work through their own emotional affects. Here we have a reversal of the process—an actual person of flesh and blood who moves through the printed pages like a wraith. When one thinks of penetrating analyses of character like Hamlet or Macbeth which are figments of their creator's imagination, one regrets that authentic biographical material should seem so thin and unconvincing.

BESSIE BUNZEL.
Metropolitan Life Insurance Company, New York City.

WOMEN WORKERS THROUGH THE DEPRESSION. Edited by Lorine Pruette. New York: The Macmillan Company, 1934. 164 p.

This is a carefully and lucidly written analysis of the employment fluctuations experienced by a group of 1,350 highly trained women, members of the American Woman's Association (the A.W.A), during the recent economic crisis. In a foreword to this most timely book, Miss Anne Morgan, President of the A.W.A., presents in brief, succinct language the manifold purposes served by the organization. She particularly stresses its educational, social, physical, economic, and cultural aspects and expresses the hope that this study may contribute to the consummation of that great objective of American life to-day—the achievement of a minimum security in the essentials of life and the opportunity of employment for all who are able to work.

Among the intriguing topics discussed in some eighteen chapters are women out of work; the occupations and earnings of salaried women; the business woman's dependents; employment security; age and job stability; leisure-time activities; the clerical worker; the married worker; and women who work for themselves. There are 31 tables which illustrate important points in the discussion, giving clarity and a scientific basis for the facts presented, the data having been tabulated from questionnaires received from 1,350 of the 4,000 A.W.A. members. The study shows the typical member of this,

perhaps the largest women's organization in the world, to be past forty, unmarried, with education and training beyond the average. One-third of the group, we are told, are engaged in the time-honored pursuit of teaching; another third are occupied with some form of clerical work; while the occupations of the remainder fall into such classifications as actress, dietitian, department manager, nurse, psychiatrist, renting agent, radiographer, telephone operator, and assistant undertaker. In this highly trained and above average group, it is somewhat startling to find that 29 per cent were unemployed some time during the depression. On the average they were out of work sixteen months. That is, during a possible working period of four years, sixteen months were passed under the destructive influence of unemployment.

To offset this disheartening observation, one turns to read a cheerful and stimulating chapter entitled, *Depression Silhouettes,* which, in a series of brief statements, presents the types of work to which 42 women successfully switched when their accustomed tasks became nonexistent. The good sportsmanship and adaptability of this group cannot be too highly commended. It is pertinent to note that not only *can* women do anything without losing prestige, but they *will* do anything in a time of economic chaos. This characteristic suggests that women's so-called tendency to scatter their interests, often referred to as a reprehensible weakness of the sex, has proved of advantage in facilitating their employment during the depression. This fact becomes convincing as one reads of the gifted singer who turned to lecturing on back-stage life, the file supervisor who became an executive housekeeper, the manager of a tearoom who became an insurance underwriter, and the bookkeeper who went into insurance selling, to name only a few of the adaptations made by these women when confronted by necessity.

The chapter closes with this salutary and very sensible statement: "The experiences of these women seem to say to other women who are out of work: Don't give up. Don't draw away from friends and groups where you may learn of new jobs. Take anything at the moment—one job leads to another job much more easily than no job does. Above all, don't stand still, don't hide away with your sorrows. Come out in the open and *keep circulating.*" Such simple, direct, and stimulating suggestions as these should be framed and hung in employment offices, where they could easily be read by all persons seeking a job, for they are the epitome of good mental hygiene in practical form.

Vocational counselors will find *Women Workers Through the Depression* of decided value in their work. It should prove of decided interest also to all women who are concerned with their own work

problems and with those of other women. Readers must remember, however, that this study applies to a highly selected group of trained women, all of whom lived and were engaged in occupations in a large urban center.

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AN INTRODUCTION TO SEX EDUCATION. By Winifred V. Richmond. New York: Farrar and Rinehart, 1934. 312 p.

This work covers much more ground than the title indicates. The author's aim, as stated in her introduction, is "to set forth something of what man has learned about his sexual nature and the problems that grow out of it." Her knowledge of how little the average individual knows about such matters was gleaned from many years of experience in lecturing on social hygiene to nurses and on personality and child development to university students. There is ample evidence throughout the book of her generous background of psychology in the emphasis with which she maintains that sex cannot be taken out of life and studied as a thing apart. Sex, to any one person, represents his present feelings, knowledge, and attitudes, which are the result of his psycho-sexual development. This, in turn, is influenced not only by the individual's heredity and environment, but by the theories, beliefs, and customs of the past. Hence, an acquaintance with primitive beliefs and customs and with the history of sexual institutions "should save us from the smug provincialism that counts those things wrong to which we are unaccustomed."

Chapter I, *General Biological Considerations,* is a short treatment of the reproductive process in plants and animals. It is devoid of hocus-pocus or futile imaginings and is included not as a means of describing sex in man, but rather to explain many of the problems of human sexual life by showing their origin in the lower forms. In this it is reminiscent of Curt Thesing's *Genealogy of Sex,* recently reviewed in these pages.[1] The second chapter, *The Biology of Reproduction in Man,* is a brief, though adequate explanation of human sex anatomy and physiology. The next two chapters, *Sex in Primitive Society* and *The Historical Period,* are absorbingly interesting. That primitive man was not aware of the relationship between sexual intercourse and reproduction of the species; that love as we now know it was not a part of sex relationship or marriage; that the reasons for marriage were varied, including need of heirs and establishment of an economic unit, and were totally foreign to our present ideas of romantic love and companionship, both of which are of comparatively

[1] See MENTAL HYGIENE, Vol. 19, pp. 142–43, January, 1935.

recent origin—all these are facts that are old to students of sociology and history, but none the less tremendously interesting to the average person.

The four final chapters, though not so grouped by the author, may be considered together, dealing as they do with the psychology of sex, problems of sex, sex and society, and sex and education. From infancy we go through various stages of psycho-sexual development, which is "the development of the thoughts, feelings, and emotional attitudes that parallel the physical development of the reproductive system from birth to maturity." These attitudes are "tremendously under the influence of environmental and educational factors—educational in the broader sense," and this is evidenced by the "various attitudes toward sex that have been held by different peoples in the history of the race, as well as those displayed by different individuals or different cultural levels in our own society." The child develops by passing through various stages. During the first four years of life there is the auto-erotic stage, including in infancy the oral and later the anal and genital stages. Still later the narcissistic and homosexual stages lead, if sexual maturity is reached, to the heterosexual goal. Poor sexual adjustment may occur anywhere along the line, and if at a low level, little can be done about it after the individual has attained the physical maturity of adulthood. There is much food here for parents and others who have something to do with the guidance of children, who should know that the giving of information relative to reproduction is but a small part of sex education.

The book is scaled to a college level of understanding, but even so will need some interpretation for students in the earlier years of college. The author has outlined the entire field of sex with a remarkable degree of efficiency, and because of this, has not given comprehensive treatment to certain details. To have done so would have defeated the general purpose of the book. Full bibliographies at the end of each chapter serve to fill in the necessary gaps.

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DYNAMICS OF POPULATION. By Frank Lorimer and Frederick Osborn. New York: The Macmillan Company, 1934. 461 p.

The population of the United States continues to grow from decade to decade. The rate of increase, however, has been rapidly declining; in fact, it has been well-established that if present trends in birth and death rates continue, the population will soon cease to grow in numbers, and may even ultimately decline. (This assumes the continuance of present immigration policies.) A thorough

analysis of population trends, however, reveals that there are differences among the important elements that make up the general population. Thus rates of growth differ as between city and country; they vary from state to state. They differ, furthermore, in the several racial and nativity groups. A process of selective reproduction is, therefore, going on, which may have important consequences upon the qualitative make-up of the future population of the United States.

Questions as to gross numbers may be studied fairly objectively. Qualitative differences—especially those of intellectual and emotional character—are difficult to dissociate from subjective bias. Consequently the literature dealing with racial differences remains highly controversial, despite the efforts to introduce objective scales of measurement. One has to tread warily indeed through the mazes of race biology, in order to seize upon true differences.

It may be said at once that the authors of *Dynamics of Population* have approached their problem with a degree of objectivity and frankness beyond reproach. They have skillfully avoided the introduction of racial and national prejudices. They have instead attempted to describe the growth of population in the United States and its social consequences as if these were laboratory phenomena. The result is a work that indubitably takes front rank in its field.

The book is divided into four principal sections. The first section describes population trends of the country as a whole, and discusses in detail geographical, racial, and social variations in reproduction trends. Part II studies physical and intellectual differences in the several population groups. The consequences of such differences are treated in Part III. The causes of the population trends, and the possibilities of controlling them are discussed in Part IV.

It is impossible in a limited review to describe the immense detail of evidence summarized with such skill in these chapters. Suffice it to say that the book is authoritative, and that it will be indispensable in the library of all interested in American demography.

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PSYCHOLOGY AND HEALTH. By H. Bannister. New York: The Macmillan Company, 1935. 256 p.

The author of this book plans to show that psychology is the bond that links physician and patient. In the first chapter he deals with the importance of a knowledge of psychology on the part of the average physician, and in a later chapter urges that no therapy

be undertaken by the psychologist except in conjunction with a physician.

There are discussions of mental defect, the problem child, and the development of the individual from normal or abnormal infancy to well-adjusted or neurotic adulthood. The varieties of psychoneurosis are outlined, and, briefly, their origin, differences, and the types of therapy valuable in dealing with them. Four short chapters are devoted to the theories of Janet, Freud, Jung, and Adler. Freud's theory of infant sexuality is refuted on the ground that there are not enough facts to make the hypotheses acceptable—and that the child's behavior can be explained in a more satisfactory fashion in other ways.

The parts dealing with treatment, by friendly rapport, suggestion, and analysis—Freudian or Jungian—are succinct and helpful. No attempt is made to describe the psychoses or institutional care of the mentally ill.

In the first portion of the book as well as in the conclusions much attention is devoted to the author's description of "sentiments," which "are organizations of the instinctive tendencies, and consequently of emotions round various objects. The organizations are built up during the course of the life of the individual. They are usually of considerable duration and have a determining influence on the individual's behavior." The child's development is pictured in terms of the sentiments that he forms first around inanimate objects, then around such animate ones as animals, and finally around abstract concepts. Normal individuals form sentiments that are very diverse and that are influenced by other individuals and environments. Sentiments become integrated to form character, and without this organization individuals lack stability.

The volume is an interesting one, though it presents little that is new to the reader acquainted with psychiatry. It does, however, give the uninformed a fairly adequate and unbiased impression of the more common psychological problems presented by individuals and the methods used by experts in dealing with them.

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NOTES AND COMMENTS

Compiled by

PAUL O. KOMORA

The National Committee for Mental Hygiene

FOURTH CONFERENCE ON PSYCHIATRIC EDUCATION

Over a hundred representatives from forty-one medical schools in the United States and Canada met in Baltimore to attend the Fourth Conference on Psychiatric Education which was held, April 8–10, at the Henry Phipps Psychiatric Clinic, Johns Hopkins University. The conference was conducted by The National Committee for Mental Hygiene, Division of Psychiatric Education, of which Dr. Franklin G. Ebaugh is director. Its purpose was to consider the various types of undergraduate teaching in this field, with emphasis on the medical student's preparation in psychiatry for hospital and general practice and only secondary consideration of postgraduate training for the special practice of psychiatry. "How can we help the new generation of physicians to be humanly and psychiatrically prepared to meet the mental problems arising in their practice?" was the query to which the conference addressed itself in three days of study and discussion devoted to the organization of courses; their content, material, and scope; patterns of teaching in classroom and ward work; time and staff allotments; clinical and out-patient training; methods of examination; therapy; and other phases of the psychiatric curriculum.

Dr. G. Canby Robinson, of Johns Hopkins Hospital, discussed the implications of the new liaison between psychiatry and general medicine from the point of view of the internist and made some practical applications in his analysis of teaching methods at this institution. "I have been very much interested," he said, "in studying the records in this hospital from a somewhat new point of view to see that the history is taken by a student or an interne, with elaborate physical examinations and a great collection of data from various sources; but in no place is there an interview." Differentiating between a "history" taken in the usual routine and an "interview" in which the physician "sits down and talks to a patient," Dr. Robinson continued, "I am quite sure that if any of our house staff who have had the training they are now getting sat down and talked to a patient for a half hour or longer, they would discover the grosser psychiatric disturbances that may be hidden away and never brought out otherwise. I have had that experience."

The interview is the thing, according to Dr. Robinson—"the bridge we should be building between internal medicine and psychiatry." In this connection, he referred to a study being made of interneships in a group of one hundred hospitals in and near New York, which showed few in which the social-service departments have developed to such an extent that the patients get such an interview by a social worker. "It is distressing to find how little interest there seems to be through these hospitals in the personality of patients," Dr. Robinson said. "There is a great deal of loss in the process of the interneship which we in the medical school would like very much to see conserved, and I doubt if it applies anywhere to the same extent that it does in psychiatry. If we can get this idea into the hospitals generally, then I have no doubt it is going to be a forward step in the advancement of psychiatric teaching, in the awakening of interest in personality, and in a concept of the patient as a whole that we who have been in medical education have been talking about a great deal, but toward the realization of which, generally speaking, we have been accomplishing very little."

As a first step in the educational process, Dr. Alan Gregg, of the Rockefeller Foundation, suggested that the importance of the psychiatric point of view, with its inclusive and comprehensive procedures, should be impressed upon the student, who must learn that the mental states related to physical disorders of all kinds cannot be disregarded. The second requirement of adequate teaching, he said, is an orderly exposition of the general body of psychiatric experience, "the kind of human experience which up to now has gone under that comprehensive term." Third is the emulation by the student of certain performances by the teacher in the educational process. "The example set by the teaching staff is of even more importance than the clarity of exposition." Fourth and finally is the idea of the students' becoming collaborators with their teachers in the study of phenomena not yet explained—the importance of "the attitude of study and of making common cause in the study of disease."

Speaking of things that it is desirable for the general practitioner to know with regard to psychiatric patients, Dr. George H. Preston, Commissioner of Mental Hygiene for Maryland, mentioned, among others, the need of the student to acquire in his course the power to discriminate intelligently between the various facilities available in the community for such patients, and the knowledge how to use them. "It is surprising to find," he said, "how little many doctors know about the specific requirements of certain legal phases of psychiatry when it comes to bringing patients under treatment."

"A growing recognition of the importance of psychiatry to general

medicine'' sums up, in a phrase, the net impression gained from the conference. As one observer remarked: ''The dominating idea in medicine for the last fifty years has been the effect on the body of the infecting agent and the tissue response to it. To-day, all through medicine, we are beginning to see that over and above this we have got a personality to deal with, and that the psychiatrists, having long been convinced of that, though in some isolation, are beginning to be recognized for what they are.''

Putting it in another way, Dr. Adolf Meyer, host to the conference, characterized the changed outlook in these words: ''As physicians we answer the call for help in distress and disease; but instead of studying only the disease, we have learned to consider also the person who has the disease. This regard for the actual person is the most characteristic recognition of twentieth-century medicine, an old story that has again come into its own and that is helping not only psychiatric, but all medical thinking, all the specialties included.''

Annual Meeting of the American Psychiatric Association

Reviewing developments in psychiatry contemporaneous with his twenty-five-year career in this branch of medicine and ranging over many topics of crucial interest to the profession at this time, Dr. Clarence O. Cheney, retiring President of the American Psychiatric Association, in his address at the association's Ninety-Second Annual Meeting, held in St. Louis, in May, singled out the recurring blight of political interference as the worst evil institutional administration is contending with to-day. Strongly condemning politically dictated appointments, Dr. Cheney pictured the misfortune that might, with poetic justice, befall politicians should they or members of their families be visited with mental disease and be placed in charge of the untrained, uninformed persons who have come to positions of authority in mental hospitals through political means. ''I have been able to imagine no more demoralizing influence on psychiatric hospitals,'' Dr. Cheney said, ''than to have appointments made or persons removed from service because of politics, and my sympathy is with those who have been less fortunate than I and who have been coerced into making such appointments or removals.''

There is a growing need of well-trained psychiatrists for hospital, clinic, and community positions, and this need, Dr. Cheney declared, can be filled only by proper and desirable medical education in psychiatry and increased opportunities for good training in mental hospitals. In this connection he criticized physicians who have become absorbed by the philosophical aspects of psychoanalysis to the detriment of sound psychiatric training, particularly those ''who do not feel drawn to medicine and to whom 'being a good doctor'

does not appeal." While paying high tribute to Freud's contributions to psychopathology and the understanding of symptoms and reactions, Dr. Cheney viewed with concern those who without such basic training "have seized upon psychoanalysis as something that, apparently for personal reasons, has appealed strongly to them to the exclusion of other psychiatric interests, sometimes apparently driven by the desire to aggrandize their own personalities by being different from the psychiatrist."

Dr. Cheney visualized the future extension of psychiatry through community channels and predicted a closer relationship between the general hospital and the psychiatrist, through which physicians will become better versed in the treatment of psychiatric problems in general practice. "As the psychiatric viewpoint and training pervade medicine," he said, "there will be an increased development of psychiatric care in the general hospitals, and there will, therefore, tend to be a decentralization from state-hospital care to local general hospitals." This, he pointed out, may be one solution of the increasing burden on state budgets, in that it may result in a decreasing tendency to send psychiatric patients immediately to state hospitals and an increasing inclination to treat them in their homes, under private or clinic medical supervision, public-health nursing, and social-service care.

The interrelations of organic diseases and mental conditions were discussed in a group of papers that summarized the results of a six-year study, at the Presbyterian Hospital in New York, of the emotional and psychic factors involved in heart ailments, diabetes, and arthritis. Dr. H. Flanders Dunbar stated that psychic factors were important in the treatment of more than half of the patients seen, and gave evidence to show that psychiatric problems are frequent and of vital significance in general medical practice. The problem is only "beginning to be seen," Dr. Dunbar said, but "the psychosomatic studies of disease entities painstakingly carried out over a number of years by diverse investigations will yield results which will transform medicine as we know it to-day."

In another application of this concept, Dr. Thomas J. Heldt, of the Henry Ford Hospital in Detroit, stressed the psychical aspect of pain and suffering and suggested that the use of opiates in surgery is rather a surgical habit than a necessity. "On final analysis," Dr. Heldt said, "pain is always psychical and in our judgment is best dealt with on that basis. Generally speaking, ten minutes spent with the patient by an attending physician, to give assurance and reassurance, will do more to allay pain than any dose of morphine. The most potent analgesic known is mental distraction. Pain of every kind and

degree can be relieved by therapeutic agents other than narcotic drugs."

Among the reports of the various standing committees of the association was one presented by Dr. Joseph W. Moore for the Committee on Legal Aspects of Psychiatry, in which the idea of limited responsibility in criminal cases was advanced. "We believe," Dr. Moore said, "that the concept of limited responsibility is one upon which our association should take a definite stand with the legal profession. Every one who has acted as a psychiatric expert has recognized among cases which do not meet the legal requirements of insanity those upon whom it is unjust to impose the full penalty of the law, but in whom a degree of responsibility exists which should not allow the defendant to escape all punishment. The psychiatrist should not be rigidly precluded from all statement as to responsibility as at present." The report further urged adoption of a resolution agreed to by the American Bar Association, advocating psychiatric examination of every prisoner convicted of a felony before he is released.

The coming of another "industrial revolution," sensed through study of the higher types of the feebleminded, the first to be affected, was pictured by Dr. James S. Plant, of Newark, New Jersey. This revolution is due, he said, to the advent of "maintenance machines" which do away with deadly monotony and require operation by workers of a superior type of intelligence. Directly affected, he said, were the types of feebleminded who up to the time of the depression had been doing "a very fair proportion of the world's work." These men excelled at the "monotonous" work, which Dr. Plant calls "repetitive."

"The high-grade feebleminded," he said, "are well equipped to perform repetitive tasks. There is no real statistical evidence as to the preëminence of the group, but there is considerable folklore and some clinical data in support of the contention that in repetitive tasks the feebleminded excel those of higher intelligence.

"We have come to recognize that a very fair proportion of the world's work is done happily and efficiently by the higher grades of the feebleminded. We have long since found that the 'production worker' is the life blood of industry and that with proper training the high-grade mental defective makes the very best of the production workers.

"The depression has increased the difficulty of employment, but we have been sure that as the wheels of industry again merrily spin, the feebleminded will no longer be on the rolls of relief organizations.

"Industry has gladly absorbed the feebleminded as 'production'

workers, but industry cannot absorb this group as 'maintenance' workers."

The following officers of the association were elected for the ensuing year: President, Dr. C. Macfie Campbell; President-Elect, Dr. Ross McC. Chapman; and Secretary-Treasurer, Dr. William C. Sandy. The next annual meeting will be held in Pittsburgh.

The National Conference of Social Work

The Sixty-third Annual Meeting of the National Conference of Social Work was held in May in Atlantic City, New Jersey.

Among the sessions of special interest to the reader of Mental Hygiene was one sponsored by the American Association on Mental Deficiency, at which Caroline M. Perkins and Mildred Thomson, of the Minnesota State Department of Public Institutions, in a joint paper, advocated the establishment of subsidized industries for mental defectives. Even if the employment situation improves, Miss Perkins pointed out, if more and more skill and efficiency are required in the modern world, we must face the supposition that a large group of defectives will be left out of work. Such a procedure may mean that sooner or later some form of subsidized industry must be provided for a large number of mental defectives, and it is important that we give careful consideration to this problem before it assumes formidable proportions." Her conclusions were based on a study of the work and wages of a group of high-grade feebleminded girls in Minneapolis and St. Paul. Few of these girls, Miss Perkins said, earn a wage sufficient for self-support. This tends to lower the wage scale and raises the question whether the mental defective, if he can do a certain job as well as a normal person, should not receive the same wage, or whether a normal person, if he can do it better, should not be employed and the wage scale upheld. "If this policy should force some mental defectives out of employment," Miss Perkins asked, "is it not better to give relief or subsidize employment for the subnormal rather than have to aid persons of normal intelligence whose morale is more easily broken?"

Education of the family of the mentally defective child, as well as of the child himself, was stressed as an important factor in the philosophy of work with the feebleminded in another paper presented at this session by Mrs. Mildred H. Ainsworth, social worker in the Wayne County (Mich.) Training School. "There is a distinct need for the education of certain types of families in the care and supervision of their mentally defective children," Mrs. Ainsworth said. "Often these parents are themselves handicapped by mental limitations and social inadequacies, and they require long and patient teaching."

In a third paper, Miss Ruth A. Gegenheimer, head social worker of the Walter E. Fernald State School at Waverley, Massachusetts, urged upon American communities the necessity for spending as much effort in providing supervised recreational and leisure-time activities for mental defectives as in trying to put them to work, if juvenile delinquency and crime are to be reduced among this group.

At a meeting of the Big Brother and Big Sister Federation, Professor Sheldon Glueck, of Harvard Law School, hailed the growing attention that law-enforcement agencies are giving to crime prevention. "Even the professional man-hunters are beginning to be aware of this," he said. "Whatever may be the ultimate outcome of preventive experiments carried on in different sections of the country, evidence like this justifies our looking to the future of crime control with at least some degree of optimism." As a hopeful indication of this, Dr. Glueck cited the awakening of the citizenry to its responsibilities for many of the community conditions that generate crime, and the energy, enthusiasm, and intelligence evident in new efforts to cope with this problem. Another sign was the "rich variety of approaches, without too slavish an adherence to any single cure-all," that characterizes crime-prevention programs in various parts of the country.

Both home and school have fallen down lamentably in the character and personality building of children, Dr. Bruce B. Robinson, Director of the Department of Child Guidance of Newark, New Jersey, declared at this same session. "The typical American public school has undermined the child's confidence by forcing him into situations where failure was inescapable," Dr. Robinson said. "Schools have lowered the child's self-respect by methods of discipline which violate all rules for mental health; they have allowed routine to interfere with the development of initiative, have allowed the recitation system to interfere with individual and social development; and by forcing the child into experiences which seem to him uninteresting and not worth while, they have led him to develop poor habits of work." Fortunately, he continued, tremendous changes in public-school policy and procedure now in the making hold out a promise of valuable contributions to the mental health of childhood, and a beginning has also been made in the better preparation of parents for the important job of child training. Dr. Robinson saw in recreation, broadly developed and not limited to "athletics," a vital factor in wholesome personality development in the future. In this connection he defined "success in recreation" in terms of "sportsmanship." "It is interesting to speculate on the influence upon society that would be exerted if childhood experiences had produced a present generation which was characterized by genuine sportsmanship, instinctive consideration of the

rights of others, and an innate inability to inflict injury on their self-respect,'' Dr. Robinson commented. ''No community agency could contribute more to our social development than would recreation if it were able to produce a definite increase in the number of adults whose personality is characterized by mature sportsmanship.''

1936 Salmon Memorial Lectures

The fourth of the annual series of Thomas W. Salmon Memorial Lectures was given at the New York Academy of Medicine last April by Dr. Samuel T. Orton, Professor of Neurology and Neuropathology at Columbia University, on the subject, ''Developmental Disorders of the Language Faculty and Their Psychiatric Import.''

Whether mothers with left-handed offspring should try to shift them into right-handedness is a question that must be answered on an individual basis, Dr. Orton stated. ''There are those who feel that such a shift never makes trouble, and in certain school systems every child is taught to write with the right hand regardless of his natural inclination,'' Dr. Orton said. ''At the other extreme are those who feel that every effort at shifting handedness of whatever character will result in some difficulty. Our own findings would place the answer to this question on an individual basis. Tests and observations of the child himself are considered necessary to determine how he should be trained, and even then it is sometimes necessary to experiment with a period of training and occasionally after such an experimental period we have found it necessary to alter the training.

''Particularly is this true in those children who are not developing a selective skill on either side. In this group it seems highly advisable definitely to attempt to increase the skills on that side which has the greatest native capacity. Of those who show a distinct preference of their own, we feel that the only logical plan is to permit them to follow this bent without outside interference, which at best probably rests upon prejudice.''

Just as there is left-handedness, so, Dr. Orton reported, there is left-eyedness and left-leggedness. Many people will consistently use one or the other eye in looking through knotholes, sighting a rifle, or peering into a microscope or telescope, and it is not always the better eye that is thus favored. These preferences are partly attributable to heredity, partly to training.

Unlike the brain centers which control the handedness of an individual, those which control the language faculty are not open to the influence of training, Dr. Orton continued. ''Autopsies have shown that language losses occur almost without exception only when damage to the brain has occurred in that half which was opposite to the individual's master hand, and in the normal living adult the only guide

we have to which is the master half of the brain is offered by studies of handedness. It is for this reason that handedness assumes importance in connection with language development in the individual."

Speech and language defects of the "word blindness" and "word deafness" type might retard the educational progress of otherwise normal children so seriously that the youngsters would be classed as dull or feebleminded, Dr. Orton said. Some sufferers from severe reading disabilities are bright enough to pull themselves up to college standing before the handicap overpowers them.

Word blindness, or alexia, is not blindness at all, in the usual sense of the term, Dr. Orton explained. The subject's eyesight may be better than normal, but he will be mentally blind to the meanings of printed or written word symbols. Some mental short-circuit blocks the normal, instantaneous, automatic process of recognizing words on sight after they have once been learned. Accurate spelling is not to be expected from these children except as they are able to learn by auditory memory. They naturally have grave difficulty with languages, history, and other reading subjects, but are often outstanding in their arithmetic classes, and in the sciences. In cases where the defect has not been diagnosed early enough to permit a careful retraining period while the student is still below college age, it probably would benefit him more to work or take vocational training than to make an effort at college study.

Study of the family background, Dr. Orton said, shows that in most cases of word blindness there is a history of left-handedness or language defects among immediate ancestors. Mothers seem to transmit the disability to their sons, and reading defects are four times as common in boys as in girls.

Disabilities in reading or writing so often go hand in hand with a stuttering condition that the early reading training of any stuttering child should be carried out with special care and thoroughness. Stuttering seems to descend through the male line of a family, and, in most cases investigators can trace in the family either a left-to-right-hand shift or a definite history of stuttering.

Word deafness, resembling word blindness, is a psychic kink which causes people who hear words perfectly to fail to understand them, Dr. Orton continued. A child suffering from this disorder will disregard the sounds of speech just as adults disregard traffic noise or other meaningless noises of the environment.

Dr. Orton also discussed two other language defects: motor agraphia, or special difficulty in writing, and motor aphasia, or speech difficulty. Motor agraphia, he explained, sometimes manifests itself as extreme slowness in writing. A child in this group will be able to write accurately and well, but may be unable to complete more than

half a normal assignment in the given time. Conversely, other children write with fair speed, but their work may be illegible. Many of these cases, Dr. Orton said, result when naturally left-handed subjects are forced to write with the right hand.

State Society News

Alabama

The Alabama Society for Mental Hygiene held its annual meeting in Birmingham last spring. Representatives of the state department of public welfare, the Children's Aid Society of Jefferson County, the Birmingham public schools, the local boys' club, the juvenile court, Alabama College, Alabama Polytechnic Institute, Birmingham-Southern College, and various hospitals and other agencies participated in the program, which dealt with the development of mental-health programs in connection with these organizations in particular and the community in general.

The theme of the conference was "The Improvement of Mental Health Conditions in Alabama." A mental-hygiene clinic, conducted by the psychiatric and psychological personnel of the Birmingham public schools, in which the case history of a problem boy was discussed from various angles, was a feature of the meeting.

The conference gave a further impetus to the work of the society, which is undertaking, among other activities, to promote courses in mental hygiene in teacher-training colleges, in collaboration with the state department of education, and to coöperate with the State Federated (Women's) Clubs, which have appointed a standing committee on mental hygiene. The formation of a bureau of mental hygiene in the state department of public welfare is also contemplated. A special committee of the society was appointed to look into the professional requirements of consulting psychologists in psychiatric practice.

The following officers were elected for 1936–7: President, Miss Hallie Green, Bureau of Tests and Measurements, Public Schools, Birmingham; Vice-President, Dr. A. H. Collins, Commissioner of Public Welfare, Montgomery; and Secretary-Treasurer, Dr. Katherine Vickery, Alabama College, Montevallo.

Massachusetts

The Massachusetts Society for Mental Hygiene reports the completion of the mental-hygiene survey of Springfield, Massachusetts, conducted during the late winter and early spring by Dr. Henry B. Elkind, medical director, and Miss Bernice M. Henderson, educational secretary, of the society. The survey dealt with the schools, courts, and correctional institutions; with child-caring, family and

relief, health, recreational, character-building, and other agencies concerned with the mental-health aspects of their problems. It noted an interest in mental hygiene "unusual for a community of such limited clinical facilities," and found the need for more training in mental hygiene among the various staffs as among the "most pressing."

The most significant finding of the survey was the lack of adequate mental-hygiene service and leadership in the face of an increasing demand from all types of organization, and the major recommendations were for a full-time child-guidance clinic, an increase in the number of psychiatrically trained visiting teachers, mental-health instruction for all teachers in the schools, a study home for especially difficult problem children, and the establishment of a branch office of the state society in Springfield.

Porto Rico Forms a Mental-Hygiene Association

The thirty-fifth country was added to the international roster of mental-hygiene societies with the incorporation of the Puerto Rican Association for Mental Hygiene at San Juan last spring. The organization, which is a dues-paying, membership corporation, will operate under a broad charter, embracing not only the reduction and prevention of mental disorders and the preservation of mental health, but also, as major goals, the mitigation of delinquency and crime, drug addiction, alcoholism, and other social problems associated with psychopathology, and the initiation of medical, legal, and educational measures to further these objectives.

The purpose of the association, as expressed in the articles of incorporation, to "appear before the legislative assembly and before the executive, administrative, and judicial authorities," reflects a determination to rely on governmental action, as well as upon educational and voluntary influences, to accomplish its beneficent ends, and the by-laws provide for the formation of a number of working committees to deal with each specific problem.

Among the immediate objectives is the establishment of the indeterminate-sentence and parole system, and the sponsoring of adequate legislation for the protection of child rights, especially in connection with the moral and legal status of illegitimate children. Psychiatry, general medicine, biology, psychology, occupational therapy, criminology, social work, and other fields are represented in the board of directors, which is composed of the following professional and social leaders of the island: Dr. Mario Juliá, Superintendent, Hato Rey Sanitarium, Hato Rey; Alfred Silva, University of Puerto Rico; Dr. J. Rodriguez Pastor, Department of Health, San Juan; Manuel Cabranes, Santurce; Luis Munoz Morales, University of Puerto Rico;

Sara R. de Gaetán, Department of Education, San Juan; María M. de Díaz Collazo, University of Puerto Rico; Jesús M. Rossy; Dr. María Cadilla de Martínez, Arecibo; Dr. Luis M. Morales, Santurce; Isabel Andréu de Aguilar; Angela Negrón Munoz; Maria E. Machín, University of Puerto Rico; Dr. José Padin, Department of Education, San Juan; Eloy Estrada, Santurce; Fulgencio Pinero, San Juan; Malvina Monefeldt, University of Puerto Rico; Samuel R. Quinones, San Juan; and Beatrice Lassalle, Department of Health, San Juan.

The executive officers of the association are: Chairman, Dr. Mario Juliá; Vice-President, Isabel Andréu de Aguilar; Treasurer, Sara R. de Gaetán; and Secretary, Manuel Cabranes.

Faith in Psychiatric Research

Faith in the premise that mental diseases are as accessible to research as physical diseases is the inspiration for the studies undertaken in the laboratory of the Boston State Hospital and described by Dr. Abraham Myerson, director of the laboratory, as opening up "one of the most fascinating and important chapters in the history of research."

Psychiatric research, Dr. Myerson points out in a recent bulletin of the Massachusetts Society for Mental Hygiene, is really research in every field of medicine, deriving its primary sources of strength and information, as it does, from the various basic sciences. "In my own lifetime," he states, "I have seen mental diseases which were of unknown origin become known, and conditions which were once believed to be untreatable become treatable and preventable." He cites general paresis and pellagra as notable examples of this.

The investigations at the Boston State Hospital, he continues, have opened the way for a modification of physiological and psychological activities in a much more precise and definite manner than has ever been possible before, and he predicts that diseases hitherto entirely inaccessible to treatment will now be mastered. While the cure of mental disease is not purchasable in the sense that one can shop around and buy cures, it is purchasable, Dr. Myerson holds, in the sense that "the community can employ and reward devoted men and women who will give their lives during the next few generations to research into the causes and treatment of the mental diseases. If the community will collaborate with the scientists in this manner, there is reason to believe that there is no mental disease which can forever resist the intelligent and faithful efforts of men to master it."

Accent on Prevention

In the belief that society should be more concerned with keeping the normal child normal than in attempting to cure him after he has become a problem child, the Children's Aid Society of New York has

set up a service unique in this field, to be known as a Department for Personal Relationships.

The new work, under the direction of Dr. Alexander R. Martin, out-patient psychiatrist at Payne Whitney Psychiatric Clinic, New York Hospital, will endeavor to apply modern procedures to a large number of children before they have shown any behavior that is likely to lead to difficulty. Dr. Martin, who was formerly Chief of Service at the Sheppard and Enoch Pratt Hospital, Baltimore, and who holds a diploma of Psychological Medicine from the Royal College of Physicians and Surgeons, London, brings to this work thirteen years' experience in psychiatry and allied fields, including specific experience in child problems gained as Director of the Child Guidance Clinic of the Baltimore County Children's Aid Society, and in research in delinquency conducted at the Maryland Industrial School for Boys.

The preventive program undertaken by the Children's Aid Society is based upon a six-months survey by Dr. Martin of the society's activities among children in six different neighborhoods in the city, with a view to finding out what could be done to prevent the development of problems and delinquency.

Because of the generally accepted opinion that the strongest factors in the problems of childhood are to be found in the child's relationship to the family, each child will be studied in relation to his home background. While many homes may disclose a breakdown of home and parental influence, giving rise to problems of discipline and control, others may show the results of undue pressure or influence of one parent.

Dr. Martin feels that one must be on the watch for the family in which, because of economic reasons, the death or separation of parents, etc., there exists between parent and child a relationship involving rejection, favoritism, indulgence, intimidation, or other strained relationships. While such factors enter in more or less degree into all family life, they may become dangerous when they are the predominating influence in any home.

Frequent round-table conferences with members of the staff will offer an opportunity for the interpretation of the child's needs and the necessary counsel and advice to the personnel. An effort will also be made, through interviews with parents, to point out to them the necessity of their modifying attitudes which are liable to produce problems in their children. The coöperation of church and school authorities in dealing with those children who have the greatest emotional needs will also be sought.

Fighting Syphilis

Syphilis infects one-tenth of the entire population of the United States and one-fourth of the persons so infected are doomed to chronic

invalidism or death, according to a statement of Dr. Joseph Earle Moore, of Johns Hopkins Hospital, at the annual convention of the New York State and Local Committees on Tuberculosis and Public Health, held in New York City, on May 19.

Despite the seriousness of the menace presented by syphilis, Dr. Moore held out great hope that this scourge might be reduced from a major to a minor problem within a generation if all the facilities within the knowledge of medicine and social science are brought to bear upon it. "It is now possible by means of the Wassermann test to diagnose 80 to 90 per cent of the hitherto untreated syphilis patients. Thus we are able to find most of those persons who have syphilis in its early forms, and who never know that they have it, and to put them under successful treatment."

Speaking on the subject of the new state program for the control of syphilis, Dr. George H. Ramsey, Assistant Commissioner of the New York State Department of Health, outlined recent legislation and the proposed steps that are to be undertaken by state and city health officials to bring syphilis under control and to prevent its spreading. In its effort to aid in the treatment of patients infected with syphilis, the state of New York has now extended its free distribution of arsenical and bismuth preparations used in the treatment of syphilis to physicians throughout the state without charge, and without reference to the financial condition of the patient. The ample scientific knowledge concerning syphilis, if properly and universally applied, would almost certainly lead to its eradication, Dr. Ramsey said.

Speaking on the same program, Savel Zimand, of the Department of Health of the City of New York, discussed the educational campaign to overcome the syphilis taboo. Placing upon the leading men and women in the community the duty of leading the public to a new orientation on the question of venereal diseases, so that the false taboos created about the subject might be destroyed, Mr. Zimand stated that general community approval is necessary if work of the public-health bodies is to become more effective.

Carl Warren, of the *New York Daily News*, spoke on changing newspaper attitudes toward the important problem of syphilis control. "A Report by the Health Department of the City of New York," Mr. Warren said, "shows that new syphilis patients have increased 63.9 per cent during the first three months of 1936 as compared to the same period in 1935. Newspaper publicity in dealing with this problem is generally credited with part of the increase." Pointing to the fact that more and more newspapers are liberalizing their rules to permit the use of heretofore tabooed words and phrases describing the social diseases, Mr. Warren stated that the words "venereal," "syphilis," and "gonorrhea," are now used whenever the context of the story

indicates it as necessary and proper. "The log jam appears to be breaking, but in order to get more spot-news publicity, the diseases need to be dramatized as tuberculosis was dramatized."

The Fiorenza Case

The inadequacies of the present method of handling criminals with psychopathic tendencies are clearly illustrated in the case of John Fiorenza, the probationer recently sentenced for the murder of Mrs. Nancy Titterton, according to a statement of the Welfare Council of New York City issued prior to his conviction. The case should serve also, the statement continues, as a reminder that society is successfully protected in thousands of cases by probation and parole systems. To quote directly:

> "Present facilities for the treatment of known psychopathic personalities are inadequate. There is no institution at the present time for their treatment. New York State has two institutions for the treatment of mental defectives; commitment to these institutions is indeterminate. The same plan might well be followed with those emotionally ill persons, not insane, who have been found guilty of crimes. It might be possible to segregate these persons in one of the present institutions in the penal system of New York State, if adequate psychiatrically trained personnel were provided.
>
> "In addition to the lack of institutional facilities, there are not sufficient psychiatric clinics in New York City which can be used by probation departments or other social agencies in the community for treatment of the many psychopathic disorders which can be treated while the person remains outside the institution. There is no place where the probationer in this case could have received free treatment by a psychiatrist. The psychiatric clinic in the Court of General Sessions, which is the only court having such a clinic, has to examine 3,000 cases a year before sentence. It does not have an adequate staff to do treatment work as well as diagnosis.
>
> "The public should not expect the impossible from probation and parole. These devices have only a certain expectancy of success, and when a man has served a term in prison, his adjustment to society is certain to be difficult, and sometimes impossible.
>
> "Probation and parole make supervision possible where otherwise there would be no protection at all to society."

Federal Courts Adopt New Procedure for Expert Testimony

Seeking to eliminate the confusion from clashing testimony by prosecution and defense alienists, two federal agencies are trying out a new plan for handling alleged mental cases in the federal courts.

According to an Associated Press report, the Public Health Service, at the request of Attorney General Homer S. Cummings, has mapped out a tentative procedure under which expert medical advice will be furnished federal judges in cases where the sanity of a prisoner is

questioned. In line with the system practiced in England, where specialists are designated as the "medical minds of the court," the new plan was inaugurated recently in the federal courts in Boston. Officials said that it would be extended to New York City, Philadelphia, Baltimore, Chicago, Minneapolis, St. Louis, Denver, and San Francisco as rapidly as plans are perfected. The Department of Justice intends, however, to continue such court experiments for a year before making a final decision as to permanent changes in procedure.

Under the plan a panel of specialists in mental disease, approved and certified by the American Board of Psychiatry and Neurology, would be selected for each federal court.

Officials who revealed the plan contended that approval of each specialist by the board, which sets minimum standards in that profession, is expected to eliminate the unqualified who are charged with responsibility for building up an "alienist racket" in courts.

Whenever a suspected or alleged mental case is brought into the federal court, the judge, under the plan, would select one of the specialists on the panel to make an examination of the prisoner and report to the court. The examination would be made under "official" circumstances, in an effort to prevent coloring of the findings by the fact that the alienist might have been retained by either the prosecution or the defense.

Since 1930 the Department of Justice, rather than the individual judge, has designated the place of confinement for federal prisoners. Attorney General Cummings, acting under that authority, now plans to extend the idea to a scientific determination of the type of treatment as well as the institution.

Boston was chosen as the place to inaugurate the revised procedure, it was reported, because Massachusetts has a Department of Mental Disease which has been coöperating with the state courts in providing expert testimony in mental cases for the court rather than for prosecution or defense.

Another Advance in Medico-Legal Reform

Two new laws passed by the New York Legislature at its last session make possible long sought improvement in the handling of inquiries into the mental status of persons accused of crime. A board has been established in the state department of mental hygiene to certify qualified psychiatrists with specified education and experience. The other law authorizes the appointment of a commission to inquire into the mental condition of a defendant in a criminal case at any stage of the case, on order of the judge as well as on request of the defendant. There must be a certified psychiatrist on such commissions, whereas

at present it is possible to appoint a commission without a psychiatrist, or even a physician, as a member.

Governor Herbert H. Lehman, in approving this legislation, characterized it as "a real advance in medico-legal jurisprudence." "These two measures," he said, "seek to remedy evils which have existed for a long time in connection with the appointment of lunacy commissions by the courts for the examination of defendants charged with crime, whose sanity is put in question." Their enactment into law represents the culmination of years of effort on the part of a number of medical, legal, and social agencies who have sought to reform existing trial procedures. One of the bills also fixes a maximum compensation for each of the members of the commission and thereby puts an end to the payment of any excessively high fees.

Marriage and Mental Health

That marriage is no barrier to insanity, but does serve as an indicator against the probability of latently developing mental disorders, and, when successful, is a sign of good mental health, was the conclusion presented by Dr. James Page and Dr. Carney Landis, of the New York Psychiatric Institute, in a joint paper read at the seventh spring meeting of the New York branch of the American Psychological Association, held at Fordham University.

Their statements were based on a study carried out under the auspices of the Columbia University Council for Research in Social Science. "Since marriage is, within limits, an objective test of psychosexual development, on the one hand, and the prime factor in eugenics, on the other," the authors said, an attempt was made "to obtain data bearing on these two problems by analyzing the mental status of 'first admissions' to mental hospitals in New York for the period of 1920 to 1934, in Massachusetts from 1929 to 1931, and in the whole of the United States for the year 1922.

"The heaviest contributors to mental hospitals are the unattached, then the divorced, and the widowed, in the order named. This, however, does not mean that marriage *per se* is a vaccine against mental disease."

The figures studied showed that for every married man admitted to mental hospitals, two widowers, three single men, and 4.5 divorced men were admitted. For women the statistics were one married woman to two single women, three divorced women, and about 1.4 widowed.

"The low rate of first admission of the married population may be most adequately explained as due to the joint operation of two factors," Dr. Page stated. "In the first place, mentally ill individuals who have homes and families are more apt to be taken care of at

home than similarly ill individuals who have no homes or families.

"Secondly, the married population is a selective group. The intrinsically maladjusted individuals who are unable to make adequate social adjustments do not marry, and the unstable individuals that do are weeded out by divorce.

"As a consequence of this selection, the single, and more especially the divorced, population are more saturated with psychopathic material than the married population and might well be expected to contribute a relatively greater number of mental-hospital candidates."

New York Hospital—Westchester Division

The Governors of the Society of the New York Hospital announce that the name of Bloomingdale Hospital at White Plains, New York, has been changed to New York Hospital—Westchester Division. The change is made, the announcement states, "in order to convey a clearer understanding than has heretofore prevailed of the relation of this hospital to the society by which it has been conducted since it was established in 1821." The new name was adopted also because of the great progress in the psychiatric work and facilities of Bloomingdale and "the closer relations with the New York Hospital, 525 East 68th Street, New York City, by the establishment there of the Payne Whitney Psychiatric Clinic." Dr. Clarence O. Cheney, formerly Director of the New York State Psychiatric Institute and Hospital and Professor of Psychiatry at Columbia University's College of Physicians and Surgeons, and now Medical Director of the Westchester Division, further explained: "The name Bloomingdale is world-famous, but the hospital governors have considered changing it for at least twenty years, not only because it failed to indicate the connection with the New York Hospital, but because in recent years it has been used in a derogatory sense by laymen, who associated it with insane asylums, which it is not." The change is effective immediately.

Mental Health in the Magazines

The growing interest of popular magazines in mental disorders as a topic of public discussion is to be noted with gratification. No longer is the subject confined to professional and technical journals, or mentioned in the hushed tones and with the reticence that characterized the public attitude in the past. Intelligent and enlightened laymen are taking a vital interest in this public-health problem and are eager to inform themselves as to its meaning and significance in personal and social life.

The past few months have seen the problem discussed in a variety of journals in a series of highly interesting, understanding, and informative articles. To mention a few, we have "Man's Last Specter

—The Challenge of Mental Disease," by Inis Weed Jones, in *Scribner's Magazine*, December, 1935; "The Nervous Breakdown," by the editors of *Fortune Magazine* in their issue of April, 1935; "Out of the Shadows," by William Seabrook, in *The American Magazine*, February, 1936; a condensation of Clifford Beer's autobiography, "A Mind That Found Itself," in the *Readers Digest*, July, 1935; "Message of Hope," by Governor Wilbur L. Cross, in *True Story*, March, 1935; and "That Queer Feeling," by Myron Weiss, in *Vogue*, April, 1936. Two articles, "Is Humanity Going Insane?" and "Your Chances of Going Insane," by Wainwright Evans, will appear in the August and September, 1936, issues of *Physical Culture*. The National Committee for Mental Hygiene collaborated in the preparation of most of these articles, and we welcome the opportunities that magazine editors and writers are offering us to present our subject to the public. They are all valuable contributions and exceedingly helpful in the promotion of our educational aims.

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